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ABSTRACT

The components of a school health program are discussed in the first section of this guide for the development of comprehensive programs in health and safety for elementary and secondary schools. A historical perspective and current trends and emphases on health education are included along with an overview of health education in Connecticut. The second section describes the philosophy and goals of a health and safety education program. The curriculum development process is discussed in the third section and includes community involvement, major program considerations, and curriculum models. In the fourth section, the content and objectives of a health instruction program are discussed: (1) community, environmental, and consumer health; (2) prevention and control of disease and disabilities; (3) first aid and emergency procedures; (4) growth and development of the human body; (5) mental health, human relations, and values awareness; (6) nutrition; (7) personal health and fitness; (8) safety and accident prevention; (9) substance use and abuse; and (10) family life education. For each of these topics, the main idea, life goals, and rationale are stated as well as the learning objectives for each elementary and secondary grade level. The fifth section is devoted to evaluation of health and safety education programs and offers sample program evaluation survey and rating instruments. The appendix contains the goals for education in Connecticut, sections of the Connecticut general statutes pertinent to health education curriculum, sample needs assessment questionnaires for community members, students, and teachers, a list of information resources available to health educators, an evaluation checklist, and a listing of Connecticut regional educational service centers. (JD)

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A GUIDE TO CURRICULUM DEVELOPMENT IN HEALTH AND SAFETY

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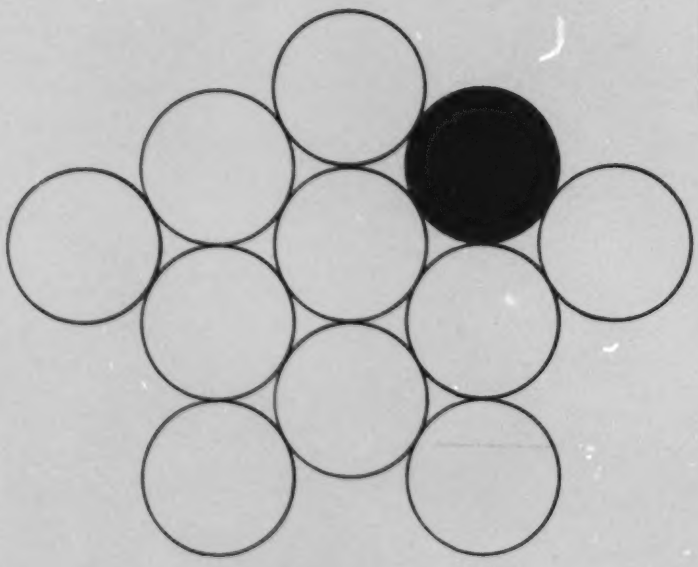

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This is one of a series of 12 guides to curriculum development prepared under the direction of the Bureau of Curriculum and Staff Development, Division of Elementary and Secondary Education, and published by the Connecticut State Department of Education. The guides may be reproduced in whole or in part as needed.

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Foreword

Connecticut has a strong commitment to equity and excellence in public education. The *Comprehensive Plan for Elementary and Secondary Education, 1980–1985*, embodies that commitment. Now this guide to curriculum development, part of a series, is one of the ways in which the State Board of Education is carrying out that commitment.

This concern for equal educational opportunity, dominant in the 1970s and continuing into the 1980s, has been expressed in a number of notable actions:

The State Supreme Court's historic school finance reform decision *(Horton v. Meskill,* 1978) led to Connecticut's educational equity legislation.

Statutes growing out of this concern for educational equity are Sections 10-262c, 10-262e and 10-16b of the Connecticut General Statutes. Sections 10-262c and 10-262e alter public school funding practices, more than doubling state support over a five-year period and setting a required minimum expenditure per pupil in each school district. Section 10-16b specifies educational programs which must be offered in all districts, with the requirement that they be "planned, ongoing and systematic."

In Connecticut's *Comprehensive Plan for Elementary and Secondary Education, 1980–1985*, submitted to the General Assembly in 1980, the State Board of Education pledged to offer local school districts a greater level of technical assistance and more positive leadership in planning, implementing and evaluating school programs.

The guides have been developed to provide tangible assistance and support to local school districts in complying with the legislative mandate. The titles of the guides correspond to the subjects which Section 10-16b requires all school districts to offer their students: the arts; career education; consumer education; health and safety; language arts, including reading, writing, grammar, speaking and spelling; mathematics; physical education; science; social studies, including, but not limited to, citizenship, economics, geography, government and history; and, at least on the secondary level, one or more foreign languages, and vocational education. The goals and objectives set forth in each of the guides relate to the

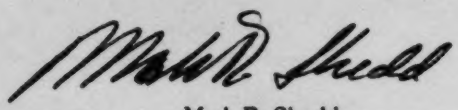
statewide goals endorsed in the *Comprehensive Plan*, namely, motivation to learn, mastery of the basic skills, acquisition of knowledge, competence in life skills and understanding of society's values.

Good health is basic to personal well-being, to optimal learning, to achievement of one's potential, and to individual development so basic for an effective society. The education of Connecticut students regarding their own health and safety, and the health and safety of the larger community, is a responsibility shared by the family, the school and the community. Future improvement in the health of the American people will result largely from actions undertaken by knowledgeable individuals. It is both a challenge and a charge to the schools to help students grow in self-awareness, acquire accurate knowledge and resources for health information, develop basic skills in decision making, and then incorporate these into their own daily health behavior and patterns of living.

The State Board of Education curriculum guides are not mandated courses of study for any student or any grade level. Each is intended solely to assist local district educators in the development of curricula. Each guide reflects the thinking and experience of an array of experts in its subject area who become, through this document, an important resource to local district educators.

The Connecticut State Board of Education frequently has expressed its conviction that the diversity of the state's public school system is one of its great strengths. Students, schools and communities do not have identical educational needs; imposing a standardized curriculum would impair, not improve, learning opportunities for students.

It is important for local district educators to keep the position of the Board in mind as they use this guide. There is much of value here which can be used to strengthen instructional practices and promote excellence in the curriculum development process. But these ideas can only enhance, not replace, the creativity, talent and commitment of the people in our local school districts who use this guide.



Mark R. Shedd
Commissioner of Education

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Introduction to Health and Safety Education 1

A Guide to Curriculum Development in Health and Safety is designed to assist educators in local school districts, community leaders and others who share responsibility and a common concern for the development of comprehensive programs in health and safety. The guide presents an instructional framework for health and safety which may be used to:

- assist local district personnel in curriculum development or revision;
- serve as reference for local administrators or school boards in program approval or evaluation, and
- become a resource for staff development programs for both educators and other interested persons.

Persons who use this guide as part of their involvement in the curriculum development process will:

- develop increased awareness of the school's role and responsibility in protecting, maintaining and promoting students' health;
- understand the breadth and scope of the total school health and safety program and the school's responsibility for providing health education, health services and a safe, healthful environment;
- understand the interdependence of the total program's components and their potential contributions to the overall educational experience of students;
- develop increased awareness of the interrelatedness of the major health education concepts, and
- establish an appropriate scope and sequence for these concepts compatible with students' developmental levels.

The curriculum development process is complex. The companion document, *A Guide to Curriculum Development: Purposes, Practices and Procedures*, delineates detailed information regarding all aspects of this process.

The purpose of *A Guide to Curriculum Development in Health and Safety* is to examine those aspects of curriculum development which are fundamental to health and safety education. This guide focuses on the curriculum for health and safety in grades kindergarten through 12. Curriculum developers should examine the concerns which are explored in this guide:

- definitions relating to health, health education and the components of the school health program;
- historical perspective of health education;
- current emphases and trends in health education;
- status of health education in Connecticut;
- rationale for a comprehensive school program in health and safety education;
- development of a program philosophy and identification of program goals;
- curricular considerations for effective development and implementation;
- specific concepts, generalizations and objectives in health and safety education;
- suggested evaluative techniques and assessment procedures, and
- resources for curriculum development and program implementation.

This chapter will examine critical definitions related to health and safety education, provide a brief historical perspective, examine current emphases and trends, and discuss health education in Connecticut. Succeeding chapters will focus on how to develop an effective curriculum.

Components of a school health program

The school is responsible for protecting, maintaining and promoting its students' health and fostering each individual's physical, mental, emotional and social development. An effective program requires the involvement and coordination of the entire school staff because the school's environment, health services and health education program are interrelated and contribute to the students' total health education experiences. The following table may be helpful in demonstrating the interdependence of the three major components which comprise a total school health program (see Table 1).

The purpose of this guide, however, is to provide guidance for only one major component of the total—that of health instruction. Before determining curriculum components, some agreement should be reached on just what health and health education are. Definitions can be critical in helping to shape curriculum design.

Most people agree that health is a multidimensional entity in which body, mind and spirit are inseparable and which is affected by the interaction of the physical, psychological, mental and social forces of each individual. If health is viewed as a continuum, then one end of it is a positive state of well-being, the "high level wellness" advocated by Dunn[1] and Ardell[2] and oriented towards a person's optimal functioning. The opposite end of the continuum is death. Along the continuum itself, there are varying degrees of illness, discomfort and disability.

Another definition of health is "a quality of life involving dynamic interaction and interdependence among the individual's physical well-being, mental and emotional reactions, and the social complex..."[3] Still one more which might be considered is that health is "the condition of the organism that measures the degree to which its aggregate powers are able to function."[4]

Table 1
The School Health Program

School Health Services	School Health Instruction	Healthful School Environment
School readiness programs including preschool health screening and assessment of emotional and social readiness	Planned health curriculum: broad program goals health instruction with teaching-learning objectives for all grade levels	Friendly staff and pupil relationships Healthful school schedule School site of adequate size, location and safety
Health appraisal by observation and periodic examination	Adequate teacher preparation and in-service	School construction meeting standards for size, sanitation, safety features, lighting, furniture, acoustics, heating and ventilation
Health counseling about physical and emotional problems for pupils and families, with referral and follow-up	Resource materials and consultation for teachers	Safety inspection, drills and patrols with pupil planning and participation
Consultation with teachers relating to physical and emotional problems encountered, and recommendations regarding participation in physical education, special education programs and other school activities	Health education for parents and other adults Educational adaptations for handicapped children	Proper school maintenance
Emergency policies, facilities and first aid	A comprehensive physical education program	Adequate and safe physical education and recreational facilities and staff
Immunizations, tests and communicable disease procedures		School lunch and milk programs that meet standards
Dental examinations, fluoride treatments and care		Safe bus operation
Cumulative records including health, accidents and social development		

From *Physician's Guide to the School Health Curriculum Process*, pamphlet by American Medical Association, 1980, Appendix I.

A curriculum development committee should begin its work by defining health in its own terms or by using one of the definitions which have been given. This definition will provide structure for the process which is to follow. From the view of what health is comes the definition of health education.

Health education is:

- providing learning experiences which prepare and motivate individuals to protect and improve individual, family and community health;
- applying knowledge to life and the processes of living;
- promoting the skills of critical thinking, problem solving and decision making;
- recognizing the interrelatedness of the physical, social, mental and emotional forces on health;
- seeking and developing patterns of behavior conducive to an optimal health level, and
- developing the ability to avoid many of the imbalances, diseases and accidents of life.[5]

The Joint Committee on Health Education Terminology has defined health education as

> a process with intellectual, psychological and social dimensions relating to activities which increase the abilities of people to make informed decisions affecting their personal, family, and community well-being. This process, based on scientific principles, facilitates learning and behavior change in both health personnel and consumers, including children and youth.[6]

Whether the committee uses one of these definitions or makes up its own, it should decide what health and safety education is before writing a curriculum guide.

A historical perspective

Comprehensive school health education has been endorsed for decades. In 1912 the National Education Association and the American Medical Association founded the Joint Committee on Health Problems in Education. This committee worked vigorously for the next 63 years identifying and addressing problems and proposing solutions related to school health services, instruction and the environment. The Joint Committee was replaced in 1975 by the AMA Medicine/Education Committee on School and College Health which includes representatives from 17 national professional organizations.[7]

The Committee on School Health of the American Academy of Pediatrics, reaffirming its support for K–12 school health education, issued the following statement in 1978:

> A basic concept of pediatrics is prevention, and health education is a basic element in the delivery of comprehensive health care. The public is continually bombarded by the media about the high cost of medical care

> and the overutilization and incorrect use of medical facilities. The media also writes about the problems of increasing promiscuity and illegitimacy; the money wasted on practices that are detrimental to the health of people in the United States, and the lag in the dissemination of new health information and facts to the public. The Committee on School Health believes that community health education programs, of which school health education programs from kindergarten through grade 12 are an integral part, are one of the most viable methods to help alleviate these and similar problems.[8]

Despite the long history of concern for comprehensive school health education all too often there has been no implementation. Among the key ingredients that have been missing are:

- teachers with professional preparation in health education
- teaching resources
- a planned sequential curriculum
- a specified time allotment

These factors have led to the present unhealthy condition of health and safety education in many school districts.

Fortunately, this situation appears to be changing. The realization that many of the debilitating, costly diseases and disabilities of later life are rooted in behavior patterns formed in childhood and adolescence has resulted in renewed emphasis on health education and a recognition of its potential as a basic component of any plan to contain health care costs.

Current trends and emphases

Health education programs today are taking a more positive approach. The focus is on life as a **dynamic process,** on **prevention** and **wellness** as opposed to illness, and on **self-responsibility** involving preventive measures and adherence to an appropriate lifestyle resulting from informed health-related decisions.

Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention,[9] notes the remarkable gains that the United States has made in reducing the infectious and communicable life-threatening diseases which earlier prevailed. The major threats today are such degenerative diseases as heart disease, cancer and stroke; accidents; environmental hazards; and behavioral factors. The report endorses a renewed commitment to disease prevention and health promotion in order to achieve further health gains and to improve the quality of life.

The Surgeon General's report suggests that the proper decisions and actions of individuals in regard to such behaviors as cigarette smoking, substance abuse, diet, exercise, observance of speed laws, use of seat belts, and periodic health screening (as appropriate) would improve health. Actions by decision makers promoting safer, healthier environments in the home, community, workplace, recreational areas, and on the road is another suggestion to achieve this goal.

The risks to health and life vary at different life stages. Since more than 95 percent of children and youths can be reached through the schools, the schools must address:

- fostering of optimal childhood development
- reduction or elimination of risk factors such as poor nutrition and child abuse or neglect
- inadequate stimuli to intellectual and psychological development which contribute to behavioral, emotional and intellectual problems

The increasing death toll from accidents and violence of children and adolescents may be traced to failures to resolve the problems of the transition from childhood to adulthood in an industrial society. At a later life stage, health risks involving chronic diseases become paramount, but the roots of these diseases often are found in the habits and behavior patterns formed early in life.

This is an era of rapid technological, social and environmental change. There are technological changes in transportation, food processing, communication and the workplace; social changes in family structure, employment patterns, life expectancy and a larger, increasingly urban population; and environmental changes in air, water and noise pollution. The all-pervasive advertising media of our society often glamorizes hazardous behaviors and presents inadequate, incomplete information which tends to confuse consumers and to foster irresponsible choices and behaviors.

Nutrition, exercise, environmental health and occupational safety, however, are increasingly emphasized. As individuals act to change their lifestyles, reduce risk behaviors, and assume more responsibility for the maintenance and promotion of their own health, gains in health status occur. Students must receive valid health information to make informed choices that will affect not only their own health but also the health of members of their families and of the community.

Health education in Connecticut

Connecticut's current curricular efforts in health and safety education coincide with the public's increased awareness and growing concern about escalating health care costs, the growth of an active health care consumer movement, and the renewed interest in school health education. Connecticut students must be helped to:

- acquire essential knowledge
- develop health awareness
- build communication and coping skills
- become constructive health decision makers

This is the direction for the future.

The School Health Task Force of Connecticut compiled data based on surveys conducted by health systems agencies and the Connecticut Advisory School Health Council as well as itself. As a result, in its report to the Connecticut General Assembly, *School Health Policy*, the task force concluded:

> ...The level of health knowledge among students in Connecticut's schools is both mediocre and uneven...Local districts run the gamut from having a comprehensive K through 12 curriculum which is implemented in the classroom to lacking even written guidelines for the mandated drug and alcohol teaching.[10]

In response to this report, the State Board of Education in February 1980 reaffirmed its commitment to school-based health education programs.

> Good health is basic to personal well-being, and health and well-being are fundamental prerequisites for effective learning. Therefore, as the agency charged with assuring each child in Connecticut an equal opportunity to a quality education, the State Board of Education commends the School Health Task Force for its valuable services in focusing public attention on the health needs of our school-aged young people.
>
> The board agrees wholeheartedly...that first-rate health education and health services for the young are very much in the public interest, not only because they promote learning and prevent needless suffering and disability, but also because they contribute to significant reductions in health care expenditures by helping to avoid or solve health problems before they require extensive medical intervention....
>
> With regard to the need for school-based health education programs, the State Board of Education feels strongly that health education is a part of the central mission of the public schools and concurs with the Task Force's position that health education, to be most effective, should be integrated with the rest of a child's school experiences....
>
> The definition of authority and responsibility for health education is clearcut in existing state law: local boards of education have the responsibility to provide a 'planned, systematic and ongoing' program to teach health and safety, and the State Board of Education has the authority to see that they do so.[11]

Given this impetus, this guide for curriculum development in health and safety education has been written. It should assist local districts as they strive to develop programs that will best meet the needs of their students in preparing them to be informed health decision makers.

2 Philosophy and Goals

One of the first tasks facing the individuals responsible for developing a local health and safety curriculum is the formulation of a philosophy and a set of broad program goals. Both should reflect and be consistent with the overall philosophy and goals of the school district. The health and safety statements of philosophy and goals will give direction and serve as referents for those responsible for planning, implementing and evaluating the district curriculum.

Program philosophy

A statement of philosophy clarifies the direction for the curriculum development effort. It justifies the inclusion of health and safety education in the curriculum, indicates the relevance of this area to educational performance, and delineates the expectations for student accomplishment. The curriculum development committee should avoid setting up unrealistic expectations. A school health education program can help students develop health-enhancing behaviors, but it is not a panacea for all the health problems that beset individuals and communities. The school, as the only societal institution which includes all children, has a sustained influence over young people during their formative years. Students in this setting may acquire the knowledge and develop the attitudes and values basic to wise decision making and appropriate action leading to the development or reinforcement of a healthful lifestyle.

The curriculum committee does not need to develop a philosophy from scratch. It can draw on other sources and adapt them to local circumstances. After defining health and health education for themselves, committee members are ready to tackle writing a statement of philosophy.

In developing a philosophy, Bedworth and Bedworth suggest that a sound philosophy of health education is one that contains a high degree of pragmatism, seasoned generously with idealism.[12] They see the philosophy statement as the cable that binds theory and practice because it would be of little value unless it resulted in practices which affected the health behaviors of students.

Another approach to writing a philosophy is that of Hamburg.[13] She suggests that a rationale for health education should encompass the following points:

- There is nothing more important to anyone than an understanding of himself/[herself] and [her]/his environment that will help him/[her] function at [her]/his highest level. Health is a means to any goal that anyone strives to achieve.
- Health is a dynamic, not a static quality, and therefore depends upon continuous, lifelong behavior. One cannot develop the highest possible degree of health early in life, for instance, and expect to maintain it automatically.
- Scientific advances with significance for the maintenance and improvement of health are occurring at a phenomenal rate. Learning about them cannot be left to chance without jeopardizing one's possibilities for a more healthful life. Learning is an important ongoing process.
- Schools can provide the educational leadership for a health curriculum which is structural and implemental in a way that can maximize the understanding and appreciation of health's personal relevance.

Of course, each district will develop its philosophy from its own perspective. A sample statement for a comprehensive health and safety education program is found in Appendix C. The important factor is that the committee members agree on a written statement that can guide their work in curriculum development and can serve to illuminate the program itself.

Program goals

Local curriculum developers for health and safety education should prepare a set of broad curricular goals. Program goals may be stated in terms of the program itself or in terms of student performance. Each district will select a format appropriate for its needs, although often student performance goals seem to be easier to use as a guide for curriculum development. (For practical suggestions about general goal setting, see the resource booklet, *Developing and Establishing Local School District Goals*, Perm Handbook Series, Connecticut State Department of Education, 1980.)

Program goals need not be developed locally. This guide includes several statements which have been developed by a variety of groups including official agencies and professional organizations concerned with health and education. These sources may be adopted or modified as appropriate to the local situation.

The Education Commission of the States has issued a report, *Recommendations for School Health Education—A Handbook for State Policymakers*. It suggests that a health education program be developed:

- to enable the student to assume individual responsibility for developing and maintaining personal behavior that promotes total wellness;
- to enhance the competencies of students to make decisions regarding personal, family and community health.[14]

Another set of goals that might be considered by the local committee is the following. It suggests that the health education program should:

- help students to gain in knowledge about the care and maintenance of their bodies, and ways to protect and improve their health;
- enable students to evaluate their own actions in relation to health and safety and to develop their potential for assuming increased responsibility in regard to their health and safety and that of others;
- help students to learn the necessary skills to adopt and maintain healthful practices and lifestyles;
- motivate students to maintain health behavior or change to more healthful practices;
- encourage students to develop a better understanding of themselves, their limits, and their potentials, and
- introduce students to community resources and the health care system.[15]

A major resource for local Connecticut curriculum developers is the report of the School Health Task Force. Its goals apply to the total school health program and are not limited to the health education component. This statement of goals, however, should be very valuable and is stated in terms of pupil performance. Therefore, it is included in its entirety.

Goal I. Physical Health

All students in public school should have and maintain a condition of good health that will make possible the realization of their maximum potential in growth, development, and participation in the educational program. Physical health, a state of an individual's well-being which is directly related to the functioning of body systems, normal growth, energy, and resistance to illness, can be achieved through a combination of knowledge, attitudes and practices.

The student will understand that body systems working properly together perform life-sustaining functions that influence growth and development.

The student will know the defenses the body has against disease and that many illnesses can be prevented and/or controlled by positive health practices.

Every student will have periodic assessment of health status. A record of the health history and status of each student should be maintained by the school to assist both in follow-up of problems and in the planning of educational programs.

Follow-up procedures should exist to ensure that health problems are treated, and that adjustments to educational programs are made as appropriate.

Every student shall be immunized against diseases as appropriate.

Every student should have adequate and appropriate food intake.

Students should receive adequate information on human sexuality to recognize the results of their behavior on themselves and others in order to make informed choices.

Goal II. Social and Mental Health

The student should know that the mentally healthy person . . . has a sense of well-being and functions effectively in life. He/she can work regularly, think clearly, manage [her/his] emotions, enjoy life, and keep on relatively good terms with most people including him/herself. (Goldenson, 1969)

The student will be helped through instruction and services to understand [her/his] mental health more fully. Personal strengths and weaknesses, emotional upsets, societal and community stress factors should receive attention.

The student will be acquainted with disabling symptoms such as severe tension, anxiety, depression and phobia, and will learn how to deal with them, knowing that discussing problems and concerns with family members, professionals and others can bring about understanding and assistance in problem solving.

The student will learn to take responsibility for the management of his/her mental health adjustment and utilize available mental health services in the school and community when appropriate.

Goal III. Health Promotion

Students should be made aware that individual behavior and environmental factors contribute to the development of a healthy society.

Students will understand that they have control over their own health status through their own lifestyle. Personal behavior affects the realization of physical, emotional and intellectual potentials.

Students will learn when and how to utilize available health services in the school and in the community.

Students will know that environmental factors affect individual health and that many of these factors can be controlled by society. [16]

This set of goals is much more specific, yet is broad enough to guide a program of health education.

Another set of goals that focus on the student has been developed by the American Medical Association. The committee might wish to consider these as a focus for its program.

Students will

- learn how one's health status is related to health behavior.
- gain understanding of growth and development . . . .
- obtain accurate information on crucial areas . . . .
- use relevant problems in developing critical thinking and decision-making skills.
- become interested in health and safety aspects of daily activities, and know proper emergency procedures.
- develop a critical attitude toward advertising of health services and products.
- discuss health-related problems, issues and topics of interest.
- examine attitudes, values and beliefs that they personally hold and those held by other students.
- explore the processes through which social values are acquired and the ways in which they can affect health.
- experience a sense of responsibility for personal, family and community health.
- develop and maintain relationships with others.
- practice skills in understanding, interpreting and evaluating health information.
- become knowledgeable about career opportunities in health-related fields.[17]

Whether a committee chooses to develop a few broadly stated goals or a more detailed, although still comprehensive, list, the program goals will give direction for further curriculum development. The statement of philosophy and program goals will benefit parents, other family members, the entire school staff and the larger community. The clear expression of why health education is essential in the public schools and of what it is attempting to accomplish will encourage more positive attitudes and participation on the part of both professionals and community members. It remains for the committee to flesh out the outline of health education provided by the philosophy and goals into a curriculum which can be implemented within the local district.

The Curriculum Development Process 3

Developing curriculum in any subject area is a complex process. The companion document, *A Guide to Curriculum Development: Purposes, Practices and Procedures*, presents this process in detail including the considerations that guide the curriculum construction: school and community characteristics, available resources (human, financial, time, material), and state and national factors. Some facets of curriculum development, however, are of special significance to health and safety education.

In this chapter, consideration of the importance of the composition of committees to insure community involvement will be addressed. Specific curriculum issues for health education will be discussed. Organizational patterns and curriculum models will be presented. Finally, other considerations that must be examined by the curriculum developers will be briefly summarized.

Community Involvement

The successful outcome of local curriculum development efforts depends heavily on the support of various groups: teachers, administrators, parents, students, health professionals, community agencies and community leaders. Therefore, local boards should insure that the curriculum development process incorporates key elements in the community. If participants in the process are drawn not only from the professional school and health communities but also from the lay people, then the health education curriculum will be developed with the broadest possible base of support. Many of the issues in health and safety education are deemed controversial by some groups. One way to avoid attack is to have broad community involvement in the curriculum process.

Committee arrangements

The selection of the curriculum development committee for health and safety education is one way to facilitate a participatory planning process which will lead to an effective and acceptable program. The school administration, usually the superintendent, should designate an individual to be in charge of health education for the district. If possible, this person should be a professionally prepared health

coordinator. In any case, the designated individual then can form the essential curriculum committees to undertake the process of evaluation of present programs and the revision or institution of new curricula.

One model for developing health education curricula suggests the formation of two committees, a school/community advisory council and a curriculum committee for health and safety. Figures 1 and 2 illustrate how the membership of these two groups would both converge and diverge. The advisory council can represent the broad interests and backgrounds of the local community and can be an ongoing participant in the school health education program. The curriculum committee, on the other hand, will consist primarily of educational staff assisted by health resource people and may or may not be in existence from year to year.

The school/community advisory council, if one is set up, should represent as many different groups within the community as possible. Its members should range from those with professional expertise in the field to those with genuine interest in achieving improved community health. Diverse viewpoints should be sought for this group. Its members should receive a written statement of how they will participate in the health and safety program of the school district. It should clarify that their role is advisory, but that their recommendations will receive serious attention. It should encourage the group to suggest improvements in the educational programs of the school. The council can provide both a valuable sounding board for ideas and an excellent resource for the staff in health education.

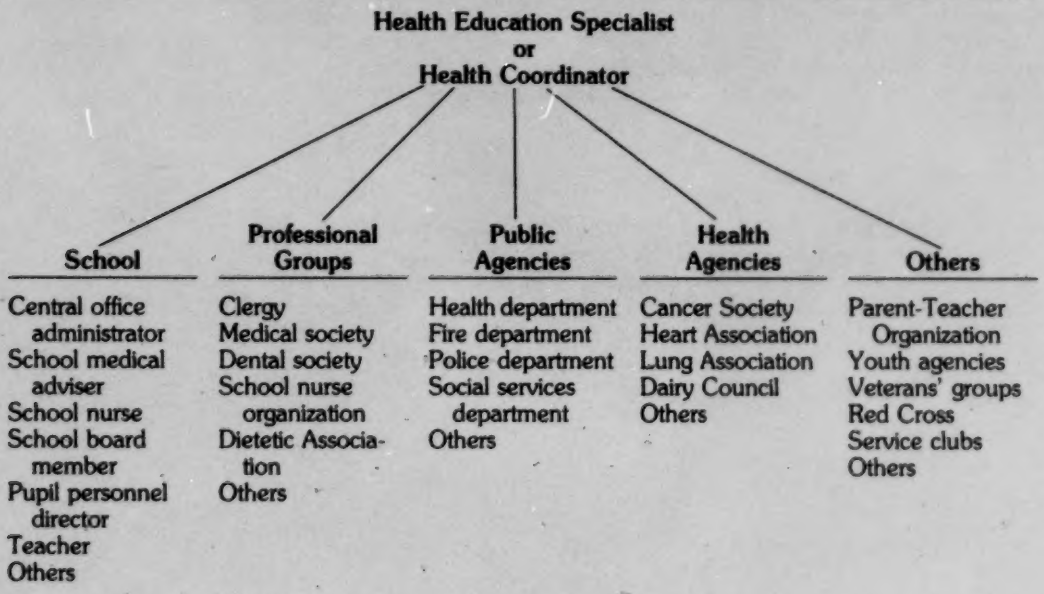

Figure 1
School/Community Advisory Council
Suggested Membership

Adapted from B.E. Pruitt, "Writing a Health Curriculum from Scratch," *Journal of School Health*. September 1980, p. 404.

The Curriculum Committee for Health and Safety Education will consist of those teachers who have a strong background in health education, health services, science, nutrition, social science, physical education and consumer education. Representative students, administrators, parents, and other faculty should be included as well as at least one representative from a public and a health agency respectively. This committee will complete the major tasks of curriculum development:

- conduct a needs assessment
- develop or revise a K–12 curriculum
- develop specific course outlines for various grade levels or courses
- identify appropriate resources for health and safety education
- plan and implement staff development programs
- evaluate the curriculum once it is in place

From this committee will come the scope and sequence of health and safety education for the local district, insuring a comprehensive and sequential program. Its members, however, should be free to use the advisory council and any other community, state or national resources that are available. The curriculum which is developed will be consistent with the statement of philosophy and the broad goals which have been established for health education.

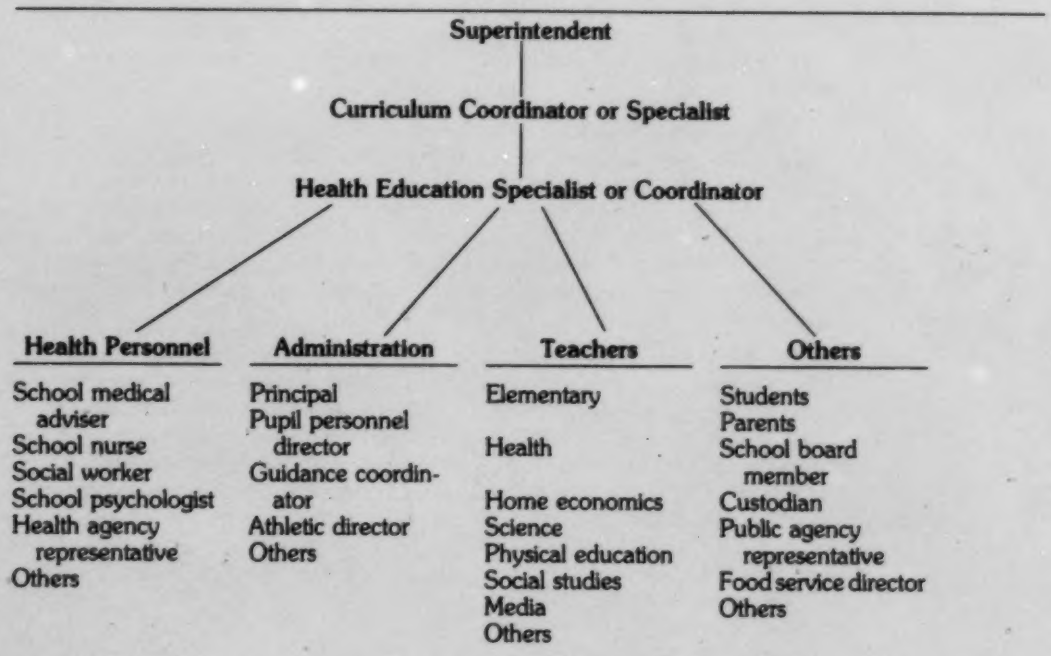

Figure 2
Curriculum Committee for Health and Safety
Suggested Membership

Adapted from B.E. Pruitt, "Writing a Health Curriculum from Scratch," *Journal of School Health*. September 1980, p. 404.

Needs assessment

Although many curricular areas can assume that some program is in place in every district, this cannot be done with health education. What is in place may be exceedingly fragmentary. Therefore, the first task facing a committee is assessing what is already in place and what is needed in the local setting. There are several ways to find the necessary information, but questionnaires are most often used. Teachers and administrators, students and community members all should be involved. The information which the committee gathers will reveal areas of duplication and unmet needs, gaps in program, and other strengths and weaknesses to guide the curriculum development process.

Students. Involving students in assessment of the strengths and weaknesses of the health education program has merit. This method also allows the committee to explore student interests and needs as clues to what the curriculum might be. Often, unnecessary duplication and repetition of subjects is quickly identified by students.

Student information can be gathered using a variety of techniques. Large and small group discussion, teacher observation, rating scales and questionnaires are valuable. A systematic survey could explore not only what students perceive the health program to be but also what their knowledge, attitudes and interests are in the field of health and safety. The committee should be cautious, however, in question construction. In some communities, parents find the questions offensive and probing of personal privacy in areas in which the school is not concerned. A sample student questionnaire is found in Appendix D.

Community members. If at all possible, the committee should strive to collect data from the community as a whole. This information can be most valuable in planning a program responsive to community needs and values. A survey of local health-related agencies and a sampling of parents will determine their perception of the needs of the community in this important area. In addition, this type of survey often uncovers interested volunteers who will work with the school in this vital area. Samples of community and health agency surveys appear in Appendix E.

Teachers and administrators. The questionnaire for teachers and administrators should be devised locally and completed by all staff members. The questions should seek to reveal what aspects of health and safety are presently taught in K–6, in health education courses in grades 7–12, and in other courses in grades 7–12. This questionnaire should seek information on the structured curriculum in the following areas:

- health courses and grade levels
- length of courses
- health topics or units within other subjects
- available teaching materials
- teacher preparation in subject area
- suggested additions or deletions
- available community resources

A sample questionnaire which might be used with teachers and administrators is found in Appendix F.

There are other methods of determining information from these sources. One is the use of the Delphi technique,[18] which uses questionnaires in a different way to help staff identify needs. Informal data can be gathered from conversations with staff and others about the effectiveness of programs. Materials can be examined as well.

Results. When all the data has been gathered, the curriculum development committee should assess it carefully. If there is a local advisory council, it should be apprised of the results and should react to them. Given this information and any data about federal, state or local mandates in the field of health and safety education (see Appendix B), the health coordinator and the curriculum committee should develop a plan for revision of the existing program or for the planning and implementation of new programs to meet expressed needs.

Major program considerations

There are several important points which should be considered in developing a health education program. A good list of these has been compiled by the Committee on School Health of the American Academy of Pediatrics. It recommends the following:

> Health education is a basic education subject, and it should be taught as such. Health education...can enhance the contribution that other basic subjects make to general life experience, understanding, and skills.
>
> Planned, integrated programs of comprehensive health education should be required for students from kindergarten through grade 12. Instruction should be given by teachers qualified to teach health education. The health curriculum should be planned and be appropriate for the age and maturity of the children at each grade level....
>
> The health education program should help teach students to use the facts and the concepts discussed for healthful living and for making knowledgeable decisions to solve personal, family, and community health problems.
>
> Financial support must be assured for health education programs because proper funding is critical in developing effective programs....
>
> Comprehensive health education programs in elementary and secondary schools should be directed by qualified health educators functioning in consultation and cooperation with school personnel, parents, students, physicians, and health agencies in the community.
>
> Health education should be a part of every elementary and secondary teachers' training program....

> School districts, other public agencies, the medical community, and private agencies should intensify their health education programs for adults as part of a coordinated community health education curriculum.[19]

As the committee considers what kind of a curriculum it will develop, there are three most common patterns of organization: integration, units within other courses, and separate courses. Each of these plans has merits.

Integration. This plan is characteristically used in the elementary grades, K–6, and involves the classroom teacher in linking health education with a broad range of subjects. Health is included in science, reading, language arts, social studies and physical education. During the elementary years, an integrated program provides maximum opportunities to imbue students with a sense of the pervasiveness of health education in many different aspects of life. The effectiveness of this approach, however, is correlated to the teacher's abilities to utilize subject matter for conveying health topics. A health education resource specialist or professionally trained health coordinator can be invaluable for classroom teachers in stimulating them to use new activities and sensitizing them to the numerous possibilities in the elementary program.

If the committee decides to use this approach at this level, then it should carefully scrutinize the curriculum for opportunities that can be used to introduce health topics. A careful survey of the teachers and administrators will yield valuable information about what is already underway. Additional materials can be developed to further infuse the curriculum with health and safety issues.

Although integration is the primary method used in the elementary school, it does not have to be the only one. It is the easiest way, however, to achieve the time goals which are suggested for health education in *A Guide to Curriculum Development: Purposes, Practices and Procedures*. With the typical pressures on the elementary day, the only way in which these allotments can be consistently maintained is through the infusion of health and safety education into other curricular areas, particularly those which convey the basic skills.

Time Recommendations

Grades	Minutes Per Week	Periods Per Week
1– 3	60 to 90	
4– 6	80 to 225	
7– 9		5 (for one semester)
10–12		5 (for one semester)

Units within courses. Teachers often develop units around health and safety topics. This is especially true in the upper elementary and secondary grades. In grades 7–12, the planned inclusion of selected units within related disciplines such as science, social studies, physical education, driver education and home economics is one possible approach. This method requires careful coordination and communication among the teachers of the various disciplines in order to avoid unnecessary repetition. Again, the health coordinator or trained specialist will be invaluable in working with these teachers.

One real problem with this approach is that many courses in the secondary levels are elective. Therefore, not all students are assured of health and safety instruction. Other ways must be found by the committee to build on the foundation laid in the integrated approach during the elementary years.

Separate courses. The secondary level is an appropriate location for separate health education courses taught by a certified health education specialist. One of these is recommended as a full semester course (5 periods a week) at both grades 7–9 and 10–12. The health course should be a dynamic experience with students sharing in the planning and participating actively in the fact-finding, exploration, discussion and critical thinking basic to informed decision making.

Direct instruction in health education is not sufficient, however. Integrated units within regular classes and infusion into other areas should continue in order to maintain a focus on health and safety for the entire K–12 experience.

Curriculum models

Before the curriculum itself can be developed, the committee must determine how the curriculum will be structured. The four most common ways to organize the curriculum in health education are by unit, by concept, by competency or a combination. Other approaches to organization are by domains, problems, chronological sequence from birth to death, or a combination of these.

By unit. The unit approach is organized around topics in the health field. Each topic comprises a unit of work, complete with materials and activities of its own. It offers the teacher the security of planned coverage in neat packages. An example of the unit approach is found in Table 2, page 20. This method, however, does not always help students develop the conceptual or decision-making skills needed for lifelong health.

By concept. The conceptual approach uses major concepts in health education to structure the learning of the students. This has the advantage of introducing a concept in the primary grades, studying it with greater depth in the intermediate grades, and finally refining it at the secondary levels. Students develop both a conceptual view of health and safety and an understanding of the organizational structure of the field which can be used to process further information throughout their lives.

The major impetus for this approach comes from the School Health Education Study which provided a conceptual model and a hierarchical structure of

concepts. This project identified the three key concepts of health education as:

- growth and development
- interactions
- decision making

Grouped under them are ten basic generalizations which form the framework for the curriculum. The curricular framework that results can be found in Table 3.

By competency. Instruction in many areas in recent years has focused on the development of minimal or "survival" competencies. This emphasis has

Table 2
A Unit Approach

Areas	Units	Grades K–3	Grade 4	Grade 5	Grade 6
Personal health	Personal hygiene	Body care Clothes care Attitude of self-appraisal relative to personal practices and posture	Value and care of the special senses Care of hair, nails, skin, and teeth	Individual practices and their interrelationship to home, school, and community	Dental health Special senses
	Nutrition	Development of good eating practices Sanitation and transportation in handling food Variety of foods in the diet	Nutritional needs Food selection when eating between meals School lunch	Processing of food	Digestion, assimilation, and excretion
	Wholesome activity and rest	Need for wholesome physical activity and rest	Relationship of muscles and bones to posture and movement		Relationship of wholesome activity to muscular and skeletal growth Need for varied activities and relaxation

From *Health Instruction: An Action Approach* by Robert E. Kime, Richard G. Schlaadt, and Leonard E. Tritsch (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1977), p. 70.

extended to health education. If this approach is adopted, the curriculum needs to be stated in terms of the long-term goals, the specific student behaviors or competencies which are to be demonstrated, and the means by which these competencies are judged to have been met. A sample of this approach is found in Table 4, page 22.

By combination. For many committees, the most satisfactory approach to health and safety curriculum development will probably utilize a combination of some or all of these approaches. This approach will identify topics which will focus the health program into manageable units, giving teachers a sense of unity. The units will incorporate key concepts from health education and generalizations

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Table 3
A Conceptual Approach

Key Concepts of Health Education	
Growing and Developing	
Body structure and function influences growth and development and vice versa.	Growth and development follows a predictable sequence, yet it is unique for each individual.
Decision Making	
Personal health practices are affected by a complexity of forces, often conflicting.	Use of stimulants and depressants arises from a variety of motivations.
Use of health information, products, and services is governed by the application of an individual's criteria.	Food selection and eating patterns are determined by physical, mental, social, cultural, and economic factors.
Interactions	
Protection and promotion of health is an individual, family, and community concern.	There is a reciprocal relationship between man, disease, and environment.
Whatever the environment, the potential for hazards and accidents exists.	The family is the basic unit of society through which certain health needs can be fulfilled.

From *Health Instruction: An Action Approach* by Robert E. Kime, Richard G. Schlaadt, and Leonard E. Tritsch (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1977), p. 70.

which illustrate the relationships among those concepts. The learning objectives for the units will specify student competencies which can be evaluated on the basis of performance indicators. In this way, the best aspects of all approaches are combined. The basic structure for health education which forms the bulk of Chapter 4 is an example of a combination approach. The learning objectives contain both behavior and content indicators to assist local committees in creating a curriculum based on this approach.

The Primary Grades Health Curriculum Project K–3[20] and the School Health Curriculum Project,[21] a complementary curriculum for grades 4–7, are structured in this way. The materials contained in the projects are complete from curriculum to teaching strategies, from media to staff development. The School Health Curriculum Project was the first health education curriculum accepted into

Table 4
A Competency Approach

Program Goal	Competencies	Performance Indicators
Students will recognize the importance of using appropriate techniques for coping with common problems of conflict and stress.	Explain the advantages of using appropriate techniques to cope with personal conflicts and stress.	Given opportunities to observe the outcomes of personal and group conflicts when decisions were made on the basis of emotional appeal, the student will illustrate how the application of problem-solving techniques might have made a considerable difference in the outcome. Given case studies of crisis situations which resulted from failure to use appropriate (accident-prevention, lifesaving, first aid, firefighting) techniques, the student will identify the techniques that should have been used and explain how their use might have changed the outcome in each situation.
	Identify acceptable alternatives for meeting various human needs (e.g., need for security, social acceptance, self-esteem)	Given an opportunity to read selected novels, plays, or autobiographies, the student will identify the desires or needs that motivate the main characters and evaluate their strategies for meeting those needs.

From *Health Instruction: An Action Approach* by Robert E. Kime, Richard G. Schlaadt, and Leonard E. Tritsch (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1977), p. 83.

the National Diffusion Network and validated by the U.S. Department of Education. Table 5 contains a sample from this program.

Other curricular considerations

After basic questions of how the health and safety curriculum will become part of the overall school program have been decided and a curriculum model has been selected, other points remain to be considered. Questions of the content of the curriculum are discussed in Chapter 4 of this guide. Problems of staffing the health education program, of selecting materials, of identifying strategies, of planning for staff development, of handling special populations, and of securing facilities will

Table 5
A Combination Approach

Area: Growth and Development

Concepts: Structure and function of the systems of the body; their interdependence and contribution to the healthy functioning of the body as a whole; reciprocal relationships between growth and development.

Lifestyle Goals: The individual
- appreciates the contribution of each of the body systems to the survival and health of the total system;
- views growth and development as a lifelong process fostered by responsible behavior.

Grade	Curriculum Level Objectives
	The student
K	• describes the growth and development of healthy teeth and gums. • explains the structure and function of teeth.
1	• names major body parts. • describes the kinds of information provided by each of the senses.
2	• describes the structure and function of the eye and ear.
3	• lists characteristics common to all living things. • describes the balanced relationships among body systems. • illustrates ways the skeletal and muscular systems work together.

Grade	Curriculum Level Objectives
	The student
4	• describes the functions of body cells in the production of energy. • explains how growth and development occurs at the level of the cell. • describes the structure and function of the digestive system.
5	• explains the physiological needs of a cell. • describes interdependence among body systems. • describes the structure and function of the respiratory system.
6	• differentiates among kinds and functions of body cells. • explains how body systems are interrelated in their functioning. • identifies the role of blood in meeting cell needs for nourishment and excretion. • describes the structure and function of the circulatory system.

From *Health Education Curricular Progression Chart*, National Center for Health Education's School Health Education Project, San Bruno, California.

be briefly enumerated here. These areas tend to be heavily influenced by local considerations and can be given only minimal guidance from outside sources.

Staffing. In this day of declining enrollments and hard-pressed school budgets, staffing for the health education program becomes a critical need. The optimal answer would be a full-time coordinator certified in health education. Failing that, a health education coordinator should be designated within the district to identify critical tasks and make recommendations to the administration. Districts might consider collaborating with one or more nearby school districts to employ a certified coordinator or contracting with one of the regional educational service centers for the part-time services of a qualified person to provide essential leadership.

Some of the tasks which can be provided by the health education coordinator are:

- helping to conduct the districtwide needs assessment for health and safety education and participating in the interpretation of its results;
- providing leadership for the curriculum committee on health and safety and the school/community advisory council, if there is one;
- serving as a resource for health-related information, instructional materials and activities;
- participating in the linkage between school health education and school health services and devising strategies to increase this linkage;
- providing technical assistance to individual schools and teachers in implementing health education programs;
- participating in the development of school policies and procedures for illness and injury;
- serving as liaison for the school system and the community including health-related agencies;
- participating in the planning and delivery of staff development workshops for teachers, administrators and other school personnel.

If the district has no coordinator, then these tasks should be apportioned among staff members. Some of them can perhaps be performed by administrators as part of their regular functions. Others can be given to teachers with special skills in health education or health professionals who volunteer to assist the schools in meeting the needs in this area.

Materials. Selecting materials for health education programs is a difficult task. Textbooks are probably not the best choice because they are so easily outdated as new information comes to light. Instead, the committee should seek the myriad of resources available from sources such as those listed in Appendix G. Government publications, newspapers, magazines, and pamphlets provide up-to-date information for the classroom. Many excellent media materials are available. For some instructional levels, there are even publications for students designed for health education programs.

Materials selected for use in health and safety programs should assist students in dealing with real-life situations. In this way, they can develop the kinds of skills which are needed for making good health care decisions in the future. Simulations, case studies, and computer games are other possibilities for students.

Another valuable resource is television. Through regular programs, instructional television series, and video tapes or discs, informative and provocative materials can be presented to students. Even the analysis of commercials will help students develop necessary skills for the future.

Strategies. Health and safety education curriculum planners can draw on the many strategies available to all teachers. They should seek particularly those which involve the students in decision making. Discussions ranging from the whole class to just a few students can be very productive. Small group learning centers, activities requiring experimentation and interaction, peer teaching, and other methods are very useful. Role playing can provide an effective means for students to develop coping skills for survival.

Students should be involved in activities which cause them to interact with the health-care agencies of the community. In this way, they can become participants as well as learners. As they become increasingly mature, students should have opportunities to act responsibly to influence matters of public health.

Staff development. Despite the almost universal endorsement of health education by national organizations and professional associations, few classroom teachers are adequately prepared in the areas of health and safety. Yet, K–6 teachers carry the primary responsibility for health education during the children's critical early years. These teachers need the assistance which can be provided by a competent health education specialist or coordinator at the district level or by a person brought in to provide this assistance.

The curriculum development committee should plan staff development workshops that will enable the teachers to carry out the new programs easily. The committee members should provide resource people who can compensate for the gaps in teacher preparation, provide updates on new trends in health care, and present new materials and activities to be used with students. Local health departments, health systems agencies, voluntary health associations, and state teacher training institutions can provide technical assistance for staff development. Consultant help can be obtained both from the regional educational service centers and the State Department of Education. Professional associations also sponsor meetings which include sessions that can be used to upgrade teacher skills and competencies in health education.

Special populations. Chapter 5 of the companion document, *A Guide to Curriculum Development: Purposes, Practices and Procedures*, discusses curriculum development for special populations. The chapter addresses key factors to be considered when planning for preschool, handicapped, gifted and talented and adult students in any curriculum area. There are a few additional considerations, however, to keep in mind when planning the health educational curriculum for special populations.

Health education is a lifelong process that begins in early childhood. The close involvement of parents and guardians in early childhood education is of vital importance in planning the health education aspects of the preschool program. A close working relationship between the home and the school can strengthen relationships and foster the development and reinforcement of mutually acceptable health-related learnings and behaviors.

In working with handicapped students, additional emphasis and consideration should be given to the health service agencies available in the community, as this information may be of significant importance for the handicapped. As with all other students, major experiential areas to be stressed include personal hygiene and cleanliness; nutrition with emphasis on good eating habits and food selection; physical fitness (including, for handicapped students, appropriate involvement in such activities as the Connecticut Special Olympics; all aspects of safety, and cautionary instruction regarding the unsupervised use of medicine).

All students should be encouraged to investigate a career choice among the more than 200 careers in the health care field. Some gifted and talented students may desire to expand their knowledge about this career field and about health-related research. For these individuals, a mentorship arrangement involving health practitioners and health facilities outside the confines of the school may be made.

Many larger communities have special health care programs and support services to meet the health needs of people with limited English language proficiency. All students, and especially those whose families would benefit from such programs, should become knowledgeable about the availability, accessibility and scope of these programs.

In planning adult learning activities, the curriculum design should be particularly flexible in order to accommodate the interests and learning expectations of the students and to help them strengthen their foundation for effective adulthood and parenthood. Topics of particular interest may include nutrition, weight control, physical fitness, sexually transmitted diseases, substance use and abuse, child development, self-care and health consumerism. The directory, *Resources for Good Health*, available from the State Department of Health Services, addresses methods and programs for changing one or more of five risk factors: high blood pressure, smoking, nutrition/overweight, stress and physical fitness. This is a valuable resource in helping consumers assume a more active role in their own health care.

Facilities. No special facilities are needed for the health education program, but the total school environment should provide for safety and be conducive to the physical, intellectual and emotional development of students. A conveniently located health suite, with appropriate equipment and supplies, should be available for the use of students and health service personnel.

Classroom instruction in health and safety education requires teachers to have access to appropriate audiovisual equipment. In addition, they should have charts, anatomical models, and other supplies as needed. Mannequins and other equipment also are necessary for teaching first aid and cardiopulmonary resuscitation.

Content of the Health Instruction Program 4

This chapter suggests a possible framework for health education that local district committees can use in constructing their own curricula. Each committee, of course, will design a program that best utilizes community resources to meet community needs.

The suggested framework is a combination approach, using elements of the unit, conceptual and competency methods. This multifaceted structure provides for optimal learning opportunities for all students. It is

- **adaptable**—it can be used with students at any grade level;
- **flexible**—it can be changed to fit student needs or community situations, and
- **permanent**—new content can be added as knowledge changes without changing the overall format.

For these reasons, this approach seems to be most useful for curriculum developers in health and safety education.

Determining the content

Each committee will construct a unique curriculum. Its members, however, should examine their program to determine if basic considerations are being met. The program content should:

- focus on concepts of individual, family and community;
- incorporate varied knowledge, attitudes and skills;
- involve the student personally;
- be action-oriented so that personal, family and community health improve;
- help students to develop optimal physical and mental health;
- force students to review and reappraise personal practices, ideas and knowledge;
- be relevant to present and future health problems.

In identifying content areas to include in the curriculum, the committee will want to review relevant legislation (Appendix B), the report of the Connecticut School Health Task Force and its recommendations, and numerous state guides

and publications. Eleven major content areas of health and safety education were selected for discussion in *A Guide to Curriculum Development in Health and Safety*. They are listed below in alphabetic, not priority, order.

- Community and Environmental Health
- Consumer Health
- Disease Prevention and Control
- Family Life Education[22]
- First Aid and Emergency Procedures
- The Human Body—Growth and Development
- Mental Health, Human Relations and Values Awareness
- Nutrition
- Personal Health and Fitness
- Safety and Accident Prevention
- Substance Use and Abuse

For each of these areas, the main ideas are comparable to the major concepts identified in the School Health Education Study.[23] The life goals cited for each major topic and main idea are adaptations of the lifestyle goals developed in connection with the School Health Education Project.[24] Each content area is subdivided into generalizations which link two or more important health and safety education concepts. Learning objectives for each generalization are subdivided according to the following grade levels:

Level I	K– 3
Level II	4– 6
Level III	7– 9
Level IV	10–12

A suggested framework for instruction is given for each of ten aspects of health and safety education. A summary of the eleventh subject—family life education—appears on page 56. (For more detail, see *A Guide to Curriculum Development in Family Life Education.*) The frameworks do not constitute a complete curriculum; rather, they provide a sample of how a curriculum might be structured. While providing guidance and direction, they do not limit in any way what a committee might write for a local district. A supplemental curriculum that includes content and activities for the ten areas is available from the State Department of Education, Bureau of Curriculum and Staff Development.

Instructional objectives

A crucial factor in writing curriculum is the development of instructional objectives. The local curriculum committee should be sure to include objectives drawn from all three domains: cognitive, affective and psychomotor. This is vitally important for the development of an effective health education program that will develop or reinforce health-enhancing habits and behaviors. The domains are interrelated and interdependent components of the health education program. Chapter 4 of the companion booklet, *A Guide to Curriculum Development: Purposes, Practices and Procedures*, gives additional information and resources that will be helpful in writing objectives from the various domains.

In the suggested framework that comprises the remainder of this chapter, Level I uses primarily the affective and psychomotor domains because the main focus is on the development of a positive self-concept, constructive attitudes and sound health habits. At subsequent grade levels, cognitive, affective and psychomotor domains all are involved as the breadth and depth of learnings increase.

Although objectives are suggested for a range of grade levels, the local curriculum committee can determine the exact level and timing of various topics. Only its members have sufficient understanding of the needs and interests of their students, the expectations of the community, and the appropriateness of each for students at many levels. Carefully developed curriculum will provide maximum flexibility and adaptability to accommodate and reflect the challenges and responsibilities presented by new discoveries, changing knowledge and developing trends in a dynamic and increasingly complex society and environment.

A basic structure for health and safety education

The framework on pages 30 to 57 is included as an example of one possible approach that the local committee may use in developing a comprehensive K–12 curriculum in health and safety education. Other viable curriculum approaches have been described and may be used. This example of a basic structure has been developed with broadly stated objectives in ten units to allow for flexibility in interpretation and implementation without loss of consistency. For the eleventh unit, Family Life Education, only the rationale, main areas and concepts from the separate publication, *A Guide to Curriculum Development in Family Life Education*, are included.

Criteria for evaluation are contained within the objectives in the specified behavior and content that the learner is expected to master. In using this basic structure, the local school systems must determine what will be appropriate, according to local needs, for

- content
- learning activities and materials for each level
- staffing
- methods of evaluation

The mission for all programs of health and safety instruction is to assist students to assume a responsible role in society, promoting individual and community health, and practicing conservation of human resources. This basic structure is a sequential program that enables students to grow into health-educated individuals. Incorporating this knowledge into the daily lives of students is the first step in accomplishing the overall mission.

TOPIC: Community and Environmental Health

MAIN IDEA: All individuals share responsibility for the identification and solution of community and international health problems.

LIFE GOALS: The individual will

- contribute to the development of community health resources needed to promote and protect the health of mankind.
- obey laws and regulations designed to protect the health of mankind.
- avoid actions that contribute to the deterioration of the environment.

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Optimal community health requires a safe and healthful environment and comprehensive health care programs.	The student will • describe things in the environment that affect a person's health. • identify community and environmental agencies and describe the services they provide. • describe different kinds of pollution and discuss possible solutions.	The student will • evaluate the importance of a healthy environment. • assess laws and regulations designed to prevent and control health problems. • discuss procedures for locating health care programs for special interest groups, i.e., elderly, handicapped, youth, etc.
The health of the community is a cooperative responsibility shared by individuals, families, communities and nations.	• discuss ways to cooperate with others to promote a healthful environment at school, in the home, and in the community. • identify different categories of community health workers.	• compare and contrast the responsibility of individuals, families, communities, and nations in responding to health regulations. • discuss methods that families can use to maintain and protect the environment where they live, work, and play. • evaluate the effects of vandalism on the school and neighborhood.

RATIONALE: The protection of health and the promotion of human comfort and well-being through control of the environment are responsibilities which result from modern conditions. The increase in population and diversity of human activities accompanying that increase have made control of the environment increasingly difficult. Large-scale programs of sanitation and environmental protection have attempted to resolve the various problems of pollution. The critical factor affecting success of such programs is neither their scope nor their funding, but the degree to which each individual cooperates in cleaning and protecting the environment.

In order to become a responsible citizen, the student first must recognize both what constitutes the environment and the resources that exist to protect and improve that environment. Secondly, the student must become actively involved in promoting improvement of the community and the environment.

Learning Objectives

III 7–9	IV 10–12
The student will • illustrate ways to conserve essential resources to protect health and improve the quality of the environment. • investigate possible health hazards associated with environmental change. • compare major world health problems, past, present, and future.	The student will • evaluate available health care for effective programming, accessibility, and quality of personnel. • design a personal plan to promote environmental quality and conservation of resources. • appraise the increased needs of basic resources to support population growth.
• appraise the health condition of the community as it relates to the individual, the family, the community, the nation, and the world. • research career opportunities in health occupations and volunteer opportunities in health agencies. • recognize that interagency cooperative planning benefits mankind.	• analyze the problems associated with communities and nations sharing resources, environmental pollution, and related health problems. • identify unmet community health needs and formulate possible solutions. • evaluate methods used to gain cooperation from individuals and community agencies to improve the quality of the environment. • participate as a volunteer in a group effort to improve community health services or environmental quality.

TOPIC: Consumer Health

MAIN IDEA: A variety of forces influences an individual in the selection of health information, products, and services.

LIFE GOALS: The individual will

- incorporate valid criteria in the assessment of health information, products and services.
- utilize services of qualified health advisers in the maintenance and promotion of his/her own health and the health of family members.

RATIONALE: Each individual is largely responsible for his or her own health. This responsibility involves not only making critical choices in

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Individuals are responsible for their own health, and many factors influence their choice of health resources used to maintain their own well-being.	The individual will • identify familiar people who assist in promoting and maintaining a state of well-being. • describe personal feelings associated with visiting medical or dental professionals. • demonstrate effective methods of communicating subjective symptoms to those individuals who provide care and treatment.	The student will • explain the value of regular medical and dental check-ups. • apply professional recommendations for treatment of health problems to daily activities. • investigate where and why family, friends, and teachers obtain health care services. • compare the cost of preventive versus therapeutic health care.
Sound criteria are necessary for the selection and use of health information, products, and services to receive the maximum benefits.	• identify various sources of health information for children. • analyze reasons for choosing commonly used health products. • discuss the cost of health products and services.	• differentiate between quackery and sound medical advice. • analyze methods used to sell health products and services. • assess the reliability of sources of health information.

terms of one's lifestyle but also choosing among a vast array of medical and health-related services, products and personnel. This combination of services, products and personnel forms perhaps the fastest growing industry in the United States today, the health industry.

Health-related information is widely disseminated via the media today, but the individual should be able to discriminate between what is valid and what is not. A person should be capable of identifying authorities on health, the various means of access into the health care system, and the community public health resources. Students must acquire a certain level of sophistication in decision making by the time they reach adulthood. Consumer health is one of the most crucial areas of the health education curriculum.

Learning Objectives

III 7–9	IV 10–12
The student will	The student will
• assess individual methods of coping with health problems.	• discuss the consumer's rights in obtaining information about one's health.
• identify and describe community agencies and specialists that provide health services.	• rate common health problems as self-care or needing professional health care.
• examine the costs and benefits of wellness versus illness.	• illustrate the relationship of values, socioeconomic status, and cultural experiences to selection of health services.
• describe types of health insurance.	• compare the concepts of national insurance and private health insurance.
• critically evaluate the role of consumer of health services.	• investigate laws and regulations designed to protect the consumer of health services and products.
• classify factors to consider when choosing health products, services, and information.	• formulate a personal list of criteria to use in selecting and using health resources.
• assess the impact of false advertising, health fads, and misconceptions on an individual's health.	• propose a plan for selecting health insurance coverage for a family.
• describe the role and function of consumer protection agencies.	

TOPIC: Prevention and Control of Diseases and Disabilities

MAIN IDEA: Prevention and control of diseases and disabilities is achievable through knowledge, self-reliance, and decision making.

LIFE GOALS: The individual will

- demonstrate responsible behavior that promotes well-being and reduces risk factors.
- develop an understanding of causes of certain diseases and disorders, and of measures to prevent, control, and treat.
- make decisions about adoption of preventive measures and promptly obtain reliable diagnosis and treatment of suspected diseases and disorders.

RATIONALE: Everyone, from birth onward, has some exposure to disease or

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
A wide variety of factors contribute to the development of chronic, degenerative and communicable diseases and health disorders.	The student will • distinguish between wellness and illness. • identify individual decisions or actions which affect illness. • identify common factors that are contributing causes of disease in children. • discuss ways in which diseases are spread.	The student will • differentiate between diseases caused by microorganisms and those caused by other factors. • inventory personal actions that contribute to decrease in wellness. • classify environmental factors that may cause disease.
Detection, prevention, and control of disease and health disorders is dependent on the individual, the nature of the health problem, and the total community or environment.	• illustrate ways to protect oneself and others from disease. • employ personal habits that promote cleanliness and reduce the risk of infection. • demonstrate ways that individuals, parents, and health professionals detect, prevent, and control health problems.	• distinguish between methods of detection, prevention, and control of diseases. • compare the treatment of communicable diseases with that of other diseases. • recognize the contribution of science in the detection, prevention, and control of disease.

risk of developing a health problem. Factors such as heredity, socioeconomic background, prenatal exposure, environment and behavior all influence the degree of risk of developing particular diseases. Also two or more risk factors may interact, reinforce and even multiply each other.

Medical advances have dramatically decreased the mortality rate due to major infections, while there has been a 250 percent increase in mortality due to major chronic diseases. There is increasing evidence that the roots of these adult chronic diseases (e.g., heart disease, stroke, diabetes, cancer) may be found in early life. Eating patterns, exercise habits and exposure to cancer-causing substances all can increase the potential for developing disease in later life. Yet, changes in personal behavior are difficult to attain when the health benefits are not visible in the short term. Students should learn to protect themselves and others from disease and should form health-enhancing habits.

Learning Objectives

III 7–9	IV 10–12
The student will • recognize symptoms of common diseases among selected populations. • examine reasons for the increase and decrease of certain communicable and chronic diseases. • assess the "risk" factor of personal habits. • classify mental, emotional, and social factors as positive or negative influences on individual wellness.	The student will • analyze different life styles and personal health practices designed to reduce risk factors in the occurrence of major diseases. • examine the role of genetic conditions in causing disease and disabilities. • discuss current research to find causative factors for major diseases.
• examine the role of medical research in detection, prevention, and control of disease and health disorders. • relate the effects of diseases to disability. • appraise the effect of disease on individuals, families, communities, and nations. • list ways to support individual and community efforts to prevent and control disease.	• employ preventive measures in personal life style and health practices. • research methods of disease detection, prevention, and control available in the community. • analyze the potential future health problems from technological advances and environmental changes.

TOPIC: First Aid and Emergency Procedures

MAIN IDEA: Applying correct emergency treatment and procedures can hasten recovery, reduce further injury, and save lives.

LIFE GOALS: The individual will

- act effectively in time of emergency, including life-threatening situations.
- apply correct emergency treatment when appropriate.

RATIONALE: The continuous emphasis which should be given to safety education and the practice of safety habits by all students at all grade levels should be reinforced further by training in first aid and cardiopulmonary resuscitation (CPR), so that students may

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Prior knowledge and specific skills are needed to act effectively during an emergency or life-threatening situation.	The student will • identify an emergency situation. • evaluate urgency of accident or sudden illness.	The student will • demonstrate basic first aid steps to take in life-threatening situations. • list people who can help in an emergency and how to contact each of them. • discuss responsibility for providing care to victims of accidents or sudden illness.
Proper emergency care helps to reduce accidents, prevent further injury, and save lives.	• demonstrate effective methods of obtaining help during an emergency.	• develop precautionary measures for specific recreational activities and describe procedures to follow in case of an accident. • develop precautionary measures for daily activities in the home and community and procedures to follow in case of an accident.

learn to act appropriately in emergency situations. Accurate knowledge of the procedures to be followed and the skills to be utilized in handling emergencies can reduce the threat to life and health.

Students will need practice time supervised by qualified instructors in order to master adequately the necessary skills. The level should be appropriate for the age and grade level of the students and subsequent grade levels should include reinforcement of these skills. The preparation of teachers as qualified instructors in CPR and/or first aid may be arranged on an individual basis with the Red Cross and/or the Heart Association or through agreements between the school system and these agencies.

Learning Objectives

III 7–9	IV 10–12
The student will • recognize limitations of first aid practices. • demonstrate proficiency in basic first aid procedures including CPR. • examine disaster plan of local community for expected behavior of individual, family, school, and community.	The student will • demonstrate proficiency in applying standard first aid procedures for major emergencies and life-threatening situations. • describe responsibilities and legal ramifications of applying first aid procedures in real life situations.
• describe what to do and not to do in an emergency. • illustrate the difference between first aid and professional treatment.	• evaluate an emergency situation quickly and respond appropriately in a simulated accident. • assess the availability and accessibility of existing emergency services in a variety of communities or environments.

TOPIC: Growth and Development of the Human Body

MAIN IDEA: The body is made up of many systems which work together enabling an individual to function both physically and mentally.

LIFE GOALS: The individual will

- accept growth and development as a predictable lifelong process, yet unique for each individual.
- strive to develop his/her full potential through sound decisions and responsible behavior.

RATIONALE: The single most significant characteristic of childhood is rapid and dramatic growth and development. Students have a nat-

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Human growth and development is both universal and unique.	The student will • compare and contrast individual similarities and differences. • identify and locate major body parts. • explain the function of the five senses. • recognize that the brain controls the body. • explain how primary and permanent teeth differ. • recognize that all living organisms come from other similar living organisms. • discuss corrective and adaptive devices used by handicapped people.	The student will • describe the basic function of cells and how they create the whole body. • illustrate ways that mental growth accompanies physical growth. • contrast growth and development patterns of male and female. • compare acquired and inherited personal characteristics. • accept limitation in development.

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ural curiosity and interest concerning the wonders and the working of the human body. This interest can become a motivating force for developing an understanding of individual growth potential and the widely diverse factors such as inherited characteristics, environment, nutrition, social conditions and personal habits which may nurture or inhibit normal growth and development.

The study of human growth and development enables students to develop both a solid foundation of knowledge of the complexities of the human machine and an appreciation of health behaviors which help to assure and maintain the optimal functioning of the human body throughout life. Growth and development is a key area in school health education.

Learning Objectives

III
7–9

The student will

- review the concept that the body is made up of systems composed of cells, tissues, and organs.
- identify the major parts of all body systems.
- identify the wide differences in physical, mental, and social growth in individuals of the same age.
- differentiate between short-term and long-lasting disparities in development.
- discuss genetic disorders which occur in certain populations.

IV
10–12

The student will

- identify the relationship of heredity to the uniqueness of growth and development.
- compare general growth patterns of males and females throughout life.
- research the aging process as part of the continuum of growth and development.
- establish criteria for measurement of growth.
- evaluate personal growth and development—past, present, and future.

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TOPIC: Growth and Development of the Human Body

MAIN IDEA: The body is made up of many systems which work together enabling an individual to function both physically and mentally.

LIFE GOALS: The individual will

- accept growth and development as a predictable lifelong process, yet unique for each individual.
- strive to develop his/her full potential through sound decisions and responsible behavior.

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Growth and development may be promoted or hindered by a number of factors, many of which are beyond individual control.	• recognize inherited characteristics. • recognize that rest, activity, and nutrition affect growth and development. • identify personal habits that may damage teeth. • identify potential hazards to ears and hearing and eyes and vision. • participate in activities that strengthen the body and contribute to correct posture.	• describe ways that the skeletal muscular system affects growth and development. • demonstrate a proficiency in caring for teeth. • illustrate ways to protect eyes and ears for maximum function in daily living. • relate cardiovascular function to growth and development. • differentiate between environmental and hereditary effects on growth and development.

RATIONALE: See pages 38 and 39.

Learning Objectives	
III **7–9**	**IV** **10–12**
• describe the effect of emotions on body functioning.	• analyze risk factors that adversely affect growth and development.
• explain the function of the nervous system in controlling the body.	• identify the advances in genetic research.
• describe the influence of the endocrine system on growth and development.	• recognize the importance of genetic counseling in inherited disorders.
• illustrate ways that normal growth and development may be adversely affected by genetic, prenatal, and neonatal "influence."	• design a personal growth plan to realize full potential.

TOPIC: Mental Health, Human Relations, and Values Awareness

MAIN IDEA: The state of mental well-being is derived from a positive self-image, a mastery of coping skills, satisfying interpersonal relationships, and an ability to behave in a manner acceptable to the individual and the society.

LIFE GOALS: The individual will

- develop and maintain a wholesome self-concept.
- understand the importance of emotions and be able to express them comfortably and appropriately.
- explore the factors that cause stress and anxiety and make sound decisions to cope with them.
- employ socially acceptable behavior patterns.
- maintain interpersonal relationships.

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Individuals constantly balance positive and negative forces that affect self-image and interaction with others.	The student will • describe positive qualities of self and others. • illustrate ways in which actions or words make one feel happy, wanted, or missed.	The student will • describe positive personal habits. • discuss the peer group as both a positive and negative influence on the individual. • assess the student's own influence on family, friends, and neighbors.
Emotions are basic to all human beings and require socially acceptable methods of expression.	• dramatize a variety of emotions. • contrast acceptable and unacceptable behavior. • describe experiences that elicit joy, sadness, anger, jealousy, hate, and pride.	• assess the effect of sex stereotype on expression of emotions. • analyze the contribution of recreational activities to emotional well-being.

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RATIONALE: Although physical growth is perhaps the easiest to recognize and evaluate during the growing years, the emotional, social and behavioral growth of a child is equally significant and dramatic. Young people must adjust to rapid individual change and simultaneously meet the expectations of family and community. The resulting strains can have considerable bearing on the problems of adolescents and young adults.

Mental health is not the absence of problems. Instead, it is the ability of an individual to use appropriate coping skills in dealing with the daily problems of living, skills that are acceptable both to the person and to society. When one looks at the statistics on youth involvement in high stress situations such as drug use and abuse, suicide, teenage pregnancy, child abuse or neglect, smoking and socially transmitted diseases, one realizes that students need help in developing the necessary skills which would enable them to negotiate successfully through these difficult situations. Carefully constructed curricula can provide the necessary experiences for students.

Learning Objectives

III 7–9	IV 10–12
The student will • formulate an acceptable balance of positive and negative feelings for self-acceptance and a good relationship with others. • investigate acceptable behavior in various cultures and lifestyles.	The student will • compare and contrast self-image and interpersonal relationships in a variety of multicultural environments. • describe ways to give and receive satisfaction with a broad range of age groups.
• describe acceptable ways to cope with strong negative emotions. • identify man's basic needs and assess their effects on emotions and behavior. • analyze the needs of the elderly.	• describe mechanisms used by individuals to satisfy emotional needs. • recognize the progression of mental illness in terms of emotional instability and mental disorganization. • assess own defense mechanisms.

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TOPIC: Mental Health, Human Relations, and Values Awareness

MAIN IDEA: The state of mental well-being is derived from a positive self-image, a mastery of coping skills, satisfying interpersonal relationships, and an ability to behave in a manner acceptable to the individual and the society.

LIFE GOALS: The individual will

- develop and maintain a wholesome self-concept.
- understand the importance of emotions and be able to express them comfortably and appropriately.
- explore the factors that cause stress and anxiety and make sound decisions to cope with them.
- employ socially acceptable behavior patterns.
- maintain interpersonal relationships.

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Man is a social being and, therefore, needs positive human relationships.	• compare the feelings of being with and without friends. • support positive feelings of others. • compare and contrast being young and being aged.	• rate factors important to a lasting friendship. • describe multiple methods of establishing good communication with peers, parents, teachers and neighbors.
Individuals vary in their ability to adjust to changes and may need help to reduce stress and anxiety in their lives.	• describe changes in life situation that make one feel upset. • discuss ways that people of various ages relieve stress and frustration.	• analyze positive and negative aspects of stress. • discuss individual choices and decisions and their relationship to reducing stress and anxiety.

RATIONALE: See page 43.

Learning Objectives	
III **7–9**	**IV** **10–12**
• compare emotional/social growth with physical growth from birth to senior citizen. • evaluate work or employment as a factor in emotional well-being. • compare man's emotional needs with society's expectation.	• describe how emotional maturity is developed. • assess own responsibilities as an adult in today's world and consider potential future adjustments. • develop criteria for good human relationships.
• analyze the causes of stress and anxiety for varying age groups. • illustrate ways that stress can affect body functions. • identify individuals and agencies that prevent and treat problems associated with an inability to cope with stress and anxiety.	• compare the characteristics of mental health and mental illness. • contrast treatment of mental illness—past and present. • evaluate own coping devices to deal with stress.

TOPIC: Nutrition

MAIN IDEA: Food intake is the source of nutrients for growth and maintenance of a healthy body. Food selection and eating patterns are influenced by numerous diverse factors.

LIFE GOALS: The individual will

- develop and maintain eating behavior that promotes personal wellness.
- make informed and responsible food choices for themselves and their family.

RATIONALE: Sound nutrition knowledge is needed to allow individuals to make wise food choices. Food habits which help build and protect good health are not acquired naturally; they must be learned. It is important for students during their early school

Generalizations	Learning Objectives	
	Level: I **Grade: K–3**	**II** **4–6**
Daily food intake is the main source of nutrients for maintaining a healthy body.	The student will • classify foods according to sources, food groups, textures, and traditions. • illustrate food combinations that provide a balanced daily diet. • describe the effect of foods on fitness and growth including dental health. • formulate lists of foods for breakfast and snacks that provide energy and nutrients for work and play.	The student will • describe the function of the major nutrients. • classify foods on the basis of nutrient content. • explain the different nutritional needs of individuals depending on age, sex, activity, and state of health. • recognize that food preparation and storage affect nutritional content and safety of foods.
Food selection and eating patterns are influenced by many diverse factors.	• analyze personal food choices. • compare similarities and differences of food choices in various ethnic groups. • select foods which promote growth and development.	• describe social and emotional influences on attitudes and eating habits. • analyze reasons for eating. • compare the cost and nutritional value of foods. • evaluate the influence of food advertising on food selection.

years to be provided nutrition knowledge and training in food management.

Several recent studies of nutritional status and food consumption suggest that many Americans are not making well-informed choices. Young children, teenagers, pregnant women and the elderly are most vulnerable to the effects of an inadequate diet. Overconsumption of food is also a serious health problem. According to estimates, 15 million Americans are sufficiently overweight to impair their health.

The Connecticut Nutrition Education and Training Program has distributed to each of the regional educational service centers instructional materials for grades K–12. Each local school district has an annotated index of these resources. Additional lesson plans and learning models in nutrition education have been developed for use by local districts.

Learning Objectives

III 7–9	IV 10–12
The student will	The student will
• illustrate how quality and quantity of food affect growth and development.	• recognize that certain health problems require dietary restrictions or supplements to attain maximum level of health.
• explain the relationship between food intake, physical activity and body weight.	• evaluate dietary needs of individual and family.
• assess the nutrient content of common food fads.	• formulate a plan to obtain optimum nutrition for self and family.
• evaluate daily food intake in terms of nutritional requirements for adolescents.	• evaluate media statements related to nutrition.
• discuss the temporary and long-term health problems associated with poor food choices and eating habits.	• discuss resources available for developing alternatives for satisfying nutritional needs despite budgetary constraints.
• assess the influence of economic, social, and emotional factors on personal eating habits.	• analyze the interrelationships of all the factors influencing personal food choices.
• describe methods used to evaluate quality of food.	• appraise the influence of the worldwide food supply on individual food choices.
	• reorganize personal eating habits as needed.

TOPIC: Personal Health and Fitness

MAIN IDEA: Personal health practices are affected by a complexity of often conflicting forces.

LIFE GOALS: The individual will

- understand that there is a constant relationship between personal behavior and wellness.
- pursue leisure-time activities that promote physical fitness.
- develop personal health practices that prevent illness and maintain health.

RATIONALE: The state of one's health invariably reflects an interplay of three major factors: environment, heredity and personal lifestyle. Of

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Wellness is much more than the absence of disease and needs a lifelong investment to be achieved and maintained.	The student will • identify the different levels of wellness. • discuss common feelings about physical handicaps. • demonstrate good dental health habits. • practice personal habits of cleanliness and good grooming.	The student will • describe variations in levels of wellness attainable by individuals. • explain why prompt attention to symptoms of illness is valuable in maintaining wellness. • discuss the importance of preventive measures for good dental health. • recognize the importance of periodic health evaluations to maintaining wellness.

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these, it is through lifestyle—one's habits and behavior—that a person directly influences the state of his or her own health. Mortality data indicates the importance of lifestyle. Of the ten leading causes of death in the United States, at least seven could be reduced substantially if persons at risk changed their health behavior. The realization that one is largely responsible for the status of one's own health is a significant step in achieving and maintaining good fitness or health.

Good health can be achieved and maintained by behaviors and practices that affect physical strength and flexibility, mental clarity and emotional stability. Eventually, such behaviors and practices become integrated into one's lifestyle as habits. In order to avoid becoming trapped within a narrow range of physical and mental habits, each individual should explore outlets for personal creativity.

Learning Objectives

III 7–9	IV 10–12
The student will • relate lifestyles to lifelong wellness. • examine personal health care problems associated with the rapid growth and emotional changes of adolescence. • identify qualified professionals for periodic evaluations and treatment or correction of health defects or problems. • formulate ways to provide opportunities for persons with handicaps to lead productive lives.	The student will • compare and contrast quality and quantity of life. • identify individual responsibility for obtaining health care from qualified sources. • appraise the services that assist handicapped persons. • construct a plan to achieve and maintain wellness.

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TOPIC: Personal Health and Fitness

MAIN IDEA: Personal health practices are affected by a complexity of often conflicting forces.

LIFE GOALS: The individual will

- understand that there is a constant relationship between personal behavior and wellness.
- pursue leisure-time activities that promote physical fitness.
- develop personal health practices that prevent illness and maintain health.

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
The human body needs a balance of sleep or rest and physical activity to relieve stress, tension, and fatigue, and to become revitalized.	• describe the difference between feeling "good" and feeling "bad." • relate sleep and rest to performance in both the classroom and during physical activity. • compare stimulating and relaxing activities.	• discuss the need for guidance in determining the proper balance of sleep, rest, and activity. • explain the structure of the body and how it functions. • illustrate how physical activity improves the body and its functions.
Physical fitness is attained through personal decisions and health practices.	• identify factors that are essential for physical fitness. • assess personal health habits. • participate in a variety of activities that promote strength, agility, coordination, and physical development. • describe how decision making affects personal health practices.	• analyze the relationship between fitness and diet. • illustrate ways in which personal choices affect health practices. • compare immediate and long-range effects of personal health choices.

RATIONALE: See pages 48 and 49.

Learning Objectives	
III **7–9**	**IV** **10–12**
• illustrate individual differences in requirements for recreation, rest, and sleep. • participate in a program of physical activities to meet her/his own needs.	• assess occupational demands and physical needs for sleep, rest, relaxation, and physical activity. • formulate a balanced program for physical fitness that can be projected throughout adult life.
• identify ways in which physical fitness contributes to physical, mental, and social health. • describe situations in which immediate gratification is traded for future health benefits. • analyze the effect of social and emotional forces on personal health behavior.	• evaluate the effect of changing technology and social forces on personal health practices. • recognize the need for motivation in attaining high level wellness. • critically analyze personal health practices and rate each as beneficial or detrimental to future health.

TOPIC: Safety and Accident Prevention

MAIN IDEA: Safe living can be attained by minimizing hazardous risks, developing safe personal habits, and realizing personal limitations.

LIFE GOALS: The individual will

- correct hazardous conditions whenever possible for themselves and others.
- follow procedures recommended for safe living.
- avoid taking unnecessary risks.

RATIONALE: Accidents are a leading cause of disability and mortality in the age group between one and 40. Students, therefore, must develop a high degree of safety awareness including a concern

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Accidents can be prevented by identifying and correcting potential hazards.	The student will • identify potential hazards in home, school, and community. • differentiate between hazards that are correctable and hazards that should be avoided. • discuss safety rules for home, school, and community.	The student will • list hazards in the environment and explain how each can be prevented from causing an accident. • describe how community groups provide protection.
Knowledge, attitudes, and behavior patterns are key factors in safe living.	• compare safe and unsafe behavior in daily activities. • recognize the danger in taking a dare.	• assess the knowledge and skills needed for safe living. • analyze the role of attitudes in causing and preventing accidents. • discuss reasons for rules in relationship to safety.

for the well-being of themselves and others and a recognition of the potential hazards and the consequences of risk taking. Through a continuous sequential program concerned with safety and emergency health care, students can build and strengthen a sound foundation of practices and behaviors which promote safe ways to work, play and live in our increasingly complex technological society.

Accidents result from both human and environmental factors. Most accidents are preventable. In many instances, they can be prevented through individual efforts such as by developing appropriate behaviors relating to pedestrian and traffic safety. In other instances, it may be necessary to marshal societal resources including those of business, industry and government, so that fitting measures are taken to correct dangerous conditions, to protect the health and safety of the public.

Learning Objectives

III 7–9	IV 10–12
The student will	The student will
• categorize major hazards on the basis of incidence and consequence.	• predict potential hazards in unfamiliar environments.
• describe ways to modify or control natural or man-made disasters.	• appraise the reasons for a higher accident rate among adolescents.
• assess individual responsibility for observing and enforcing safety regulations.	• evaluate the role of community groups in reducing environmental hazards.
	• examine the complexities of risk taking.
• recognize a correlation between emotions and accidents.	• explain the utilization of community resources during a disaster.
• explain uses of safety equipment in schools, homes, and community.	• evaluate accident data in relation to the impact on the individual, family, school, and community.
• formulate appropriate attitudes, habits, and skills to insure safety in everyday life.	• construct a plan for safe living.

TOPIC: Substance Use and Abuse

MAIN IDEA: Substances that modify mood, physical condition, or behavior are used and abused for a variety of reasons.

LIFE GOALS: The individual will

- make responsible decisions on the use of substances or appropriate alternatives to fulfill personal needs.
- refrain from the abuse of any potentially harmful substance.
- obey laws and regulations regarding the use of controlled substances.

RATIONALE: At all levels and ages, prevention is the primary objective of education in substance use and abuse. Programs should in-

Generalizations	Learning Objectives	
	Level: I Grade: K–3	II 4–6
Substances can be beneficial or harmful to humanity and should be handled with care and caution.	The student will • differentiate between substances that are harmful and helpful. • identify common nonfood substances and plants that may be harmful or allergenic. • describe the correct use of medicines.	The student will • compare the short- and long-term physical and mental effects of use/misuse of substances including medications. • analyze the effects and hazards of common substances used by youth. • discuss the legal and social offenses of using drugs, tobacco, and alcohol.
The decision to use and/or misuse a substance or to choose an alternative is made by the individual on the basis of values and needs.	• define habits and discuss their influence on health. • illustrate the influence of advertising on use or misuse of substances. • recognize that customs, values, rules, and laws influence the use of substances in our society. • practice activities that promote positive feelings during free time.	• evaluate the factors influencing an individual to use/misuse a substance. • rate pleasure-seeking activities as preferred alternatives to misuse of substances. • identify individuals and agencies providing assistance in prevention of substance abuse or related problems.

clude effective educational strategies that stress the concept of individual responsibility for the daily decisions that affect health.

Cigarette smoking is a crucial school health issue. Smoking has been identified as the cause of most cases of lung cancer and as a major factor which increases the risk of heart attack. Cigarette smoking, therefore, is the single most important preventable cause of death.

There is no question that drug and alcohol use and abuse are national problems. Both alcohol and drug misuse exact a substantial toll in the form of preventable deaths, illnesses and disabilities. This misuse also contributes to family problems, poor school and job performance, and can lead to long-term chronic disease. Since 1962, drug experimentation and frequency of use has increased greatly. Successful education may be one way to combat this trend.

Learning Objectives

III 7–9	IV 10–12
The student will • contrast social/psychological effects of substance use with physiological effects. • compare the expected beneficial effects of prescribed medications with the hazards of self-treatment. • illustrate the potential danger of substance use that interferes with normal body functioning. • explain reasons for laws regulating drug use and handling of controlled substances.	The student will • classify acute and chronic health problems associated with substance use/misuse. • compare/contrast the legal and illicit handling of controlled substances. • discuss the medical, economic and social problems caused by drug abuse. • formulate an action plan to prevent misuse of substances.
• analyze individual inner needs and acceptable methods for meeting those needs. • discuss the views of society concerning the use of controlled substances. • assess peer pressure on personal value system. • compare prevention programs and treatment programs available in community.	• evaluate ways of assisting others in meeting their inner needs. • develop a sense of responsibility for one's own welfare and that of others. • analyze the interaction between an individual's needs and the social environment as influences on the individual's use of substances.

TOPIC: Family Life Education

MAIN IDEA	CONCEPTS
Planning for Family Life	Family structure—the composition of family units Religious and cultural beliefs Reproduction Family planning Change
Human Sexuality	Self-concept Sexuality Interpersonal relations
Parenting	Self worth Self-expression and interpersonal skills Knowledge of development Knowledge of resources
Nutrition	Importance of nutrition Nutrients Food management Societal influences

Note: Suggested instructional objectives, content and sample activities for each concept appear in *A Guide to Curriculum Development in Family Life Education*, Connecticut State Board of Education, 1981.

RATIONALE: Currently, family life is characterized by increasingly complex and changing patterns, a rapid increase in one-parent families, the decrease of the two-parent family model and less parental assurance about appropriate behavior models for the young adolescent. In both the two-parent family and the one-parent family, the increase in employment on the part of parents results in an increased sharing of the responsibility for teaching the understandings of family living. This may result in students' lack of coherence in learning the knowledge and values related to family life. Students often show confusion and even ignorance regarding such basic family learnings as health and nutrition, sex education, moral and ethical values and the caring relationships inherent in sound family life.

We enter the decade of the eighties with a need for concerned, cooperative, affirmative effort. This effort to develop sound, viable and responsible programs and resources to meet the needs of family living should involve parents, guardians, students, the school, religious institutions and community agencies.

In identifying its role, the school should recognize the primacy of parental rights and responsibilities in the education of their children for family living, and should further recognize that, in addition to developing a role for the school with students, the school should be seeking an educative role with parents as they carry out their responsibilities to their own children. Since many of the concepts of family living involve ethical and moral values, the school should involve religious institutions and other community agencies in planning, implementing and evaluating the program, while maintaining the appropriate separation of church and state.

In the development of family life programs, the public schools should consider the following as characteristics of appropriate programs. The programs must:

- be sensitive to the differing ethical values, moral standards and religious teachings of students and their parents;
- seek to assure the ethical and moral dimensions of human sexuality as part of the awareness considered in the development of the program, and
- reject the advocacy or teaching of any one sectarian doctrine or any amoral doctrine.[25]

5 Evaluation

A crucial aspect of the curriculum development process is evaluation. The committee should identify or develop suitable evaluation instruments both for assessing program appropriateness and student performance in terms of stated instructional objectives. Ongoing evaluation procedures are essential to insure the continuity of the curriculum development process.

Table 6
Sample Survey Instrument

Directions: Consider the health and safety instructional program for the district. Then answer these questions.

	Yes	No
The health and safety curriculum		
• motivates students to reach their potential to learn?	___	___
• develops positive feelings of self worth?	___	___
• helps students develop responsible health and safety behaviors?	___	___
• encourages students to communicate with others effectively orally?	___	___
• encourages students to communicate with others effectively in writing?	___	___
• provides opportunities for students to use basic reading, language and mathematics skills?	___	___

Program evaluation

Evaluation instruments structured in terms of local district objectives and goals for health and safety instruction will provide essential program information. Curriculum strengths and weaknesses will be revealed, indicating where modifications or revisions should be made. If there is a School/Community Advisory Council, it should work with the curriculum committee in carrying out evaluation procedures and in interpreting results.

Often, school districts enter the curriculum development process as a result of evaluative procedures. It is equally important, however, for the committee to provide for ongoing assessment of the revised program. Sometimes, this is done first with small-scale pilot programs. At other times, data are gathered after the program has begun full implementation.

The local committee can use many different kinds of instruments for program evaluation. These include checklists, interviews, rating scales, structured discussions, surveys, and teacher-developed tests. The companion guide to overall curriculum development discusses this aspect of evaluation in some detail.

One way to design a survey instrument is to structure it around the statewide goals for education combined with the local goals for health and safety. An example of the kinds of questions a committee might include in such a survey is shown in Table 6.

	Yes	No
• develops decision-making skills?	___	___
• helps students acquire basic health and safety information?	___	___
• helps students understand how to creatively maintain good health?	___	___
• encourages students to understand how good health and their multiple roles in life are interrelated?	___	___
• encourages students to consider health-related career choices?	___	___
• helps students develop a commitment to good health and fitness for their entire lives?	___	___
• encourages students to evaluate their ideas and beliefs about health and safety?	___	___
• allows students to make health decisions based on personal values?	___	___
• encourages students to realize that good community health practices reflect societal values?	___	___

Another way to evaluate Connecticut programs in health and safety education is to use a rating scale based on the goals of the School Health Task Force. (For a summary of these goals, see page 10.) A sample of what this might look like is found in Table 7.

Still a third model which might be adapted for local use is the survey which has been developed by the American Medical Association. This has been reproduced for use by curriculum committees in Appendix H. Local districts will probably pick and choose among its questions according to local needs.

Whatever instrumentation is used, the curriculum committee should feel that its tasks are complete only when:

- proper evaluation instruments have been identified or developed;
- program evaluation plans have been set up;
- students, staff and community members clearly understand the role each plays in evaluating the program, and
- procedures for ongoing review and revision of health and safety education have been established.

Table 7
Sample Rating Scale

Directions: Think about the current health and safety curriculum in this district. Then, rate its effectiveness on each of the points given below. Put a check at that point on the scale which indicates how effective it is today. If it is very effective, put your check mark at the right side of the scale. If it is very ineffective, put your check mark at the left side of the scale. If it is some where in between, try to put your check mark at the point which seems appropriate.

	Very ineffective				Very effective
• Does the program develop student understanding of body systems and their effective functioning?	/	/	/	/	/
• Does the program develop student knowledge of disease, the body defenses against it, and disease prevention and control techniques?	/	/	/	/	/
• Does the program provide students with sufficient information on nutrition so that they can make wise decisions on food choices?	/	/	/	/	/

Student performance evaluation

A second important committee responsibility is the provision of means for evaluating the performance of students in terms of the cognitive, affective and psychomotor objectives of the program. Teachers, administrators, health professionals and others will want to know how effectively the students are developing health-related knowledge, attitudes, skills and behaviors. The committee should provide teachers with both suggestions and sample instruments for determining levels of pupil performance in all domains. Both objective and subjective assessment procedures should be included. Some of these might be:

- pre- and post-tests to determine student knowledge, attitudes and skills related to health;
- student self-evaluation scales and surveys on health status and practices;
- simulations;
- interviews and discussions, and
- teacher observations.

	Very ineffective				Very effective
• Are students helped to a good understanding of mental health and how to maintain it?	/	/	/	/	/
• Does the program explain the symptoms of poor mental health and develop coping skills?	/	/	/	/	/
• Does the program help students develop control over their health status by controlling their lifestyle?	/	/	/	/	/
• Does the program help students realize the effects of their own behavior on health?	/	/	/	/	/
• Does the program expose students to available health services?	/	/	/	/	/
• Does the program help students understand how the environment affects health and how it can be controlled by society?	/	/	/	/	/

A variety of instruments should be provided so that teachers are able to match student learning styles with the assessment instruments that will yield the best information on performance.

Assessment of student performance in terms of cognition is relatively simple. The construction of tests and other devices that will allow students to demonstrate their knowledge about health and safety is the same as it is for any other curricular area. The instruments should allow for both informal and formal testing and should not be limited to paper/pencil situations. Activities that demonstrate use of knowledge are useful.

Evaluation of student performance in terms of health and safety skills is a little more difficult. The committee can provide a number of situations such as role playing or simulations in which students actually demonstrate their skills in various situations. In evaluating first aid skill, for example, the tests would obviously incorporate demonstrations of actual practice rather than written descriptions of what might be done. In this way, levels of student proficiency can be evaluated.

The most difficult area of assessment is that of attitudes and behaviors that promote lifelong health. Evaluation of short-range performance often bears little relationship to the eventual long-term effectiveness of the program and of students' behavior. Attitude surveys, observations by teachers of how students react in varying situations, logs in which students record health behaviors and attitudes are ways in which assessment of present performance can be made. Effective long-term evaluation, however, is not possible in most instances.

There is little available for use in the field of health and safety education that has been standardized across the nation. In this very personal field, most evaluation of student performance is on an individual basis in terms of objectives rather than on a group basis in terms of comparability of achievement. Perhaps, as more schools stress health education, there will become available instruments that can be used to measure how well students are doing in comparison with national norms.

Connecticut Assessment of Educational Progress

As part of its plan to meet the State Board of Education's goal of "evaluating success," the State Department of Education is engaged in the Connecticut Assessment of Educational Progress (CAEP). This is a program designed to provide local school systems with positive leadership by evaluating the adequacy and efficacy of state educational programs in a variety of fields.

CAEP is modeled after the National Assessment of Educational Progress (NAEP). Although NAEP did not originally include evaluation of health education, a limited assessment of basic life skills and health-related questions was initiated in 1975, in keeping with the goal of providing the public with information about educational concerns related to current social issues. This assessment was administered only to 17-year-olds attending school and to adults, ages 26–35.

CAEP's evaluative responsibilities include conducting assessments in the 11 instructional areas cited in C.G.S. 10-16b at five-year intervals. CAEP also

compares Connecticut performance with a national and northeast standard by using a common pool of NAEP items. Strengths and weaknesses for Connecticut programs are determined by comparison of results with pre-established standards of performance.

During the 1984–85 school year, 11th graders will be tested in health and safety. Comparisons will be made with the NAEP results to determine how well state programs are preparing students. The implications of CAEP should be considered by curriculum committees when modifying and revising local programs.

Summary

Evaluation is an essential, integral component of the curriculum development process. The local curriculum committee must design a continuous evaluative process and develop monitoring instruments and procedures which measure the overall effectiveness of programs in terms of stated goals and objectives. As each local school district strives to achieve excellence and effectiveness, it will find the information obtained through continuous assessment of program and student performance an invaluable aid in indicating future direction and necessary revisions in the health and safety curriculum.

Appendix A
Statewide Goals for Education

From Connecticut's *Comprehensive Plan for Elementary and Secondary Education, 1980–1985*

GOAL ONE

Motivation to Learn

To realize their potential to learn, students must be highly motivated.

Therefore:

Connecticut public school students will develop strong motivation by responding to the high expectations of their parents, teachers and school administrators; by understanding and striving to fulfill personal aspirations, and by developing the positive feelings of self worth which contribute to responsible behavior and personal growth, health and safety.

GOAL TWO

Mastery of the Basic Skills

Proficiency in the basic skills is essential for acquiring knowledge and for success in our society.

Therefore:

Connecticut public school students will, to their full potential, learn to communicate effectively in speech and writing; read with understanding; acquire knowledge of and ability in mathematics, and strengthen decision-making skills.

GOAL THREE

Acquisition of Knowledge

Acquiring knowledge leads to fuller realization of individual potential and contributes to responsible citizenship.

Therefore:

Connecticut public school students will acquire the knowledge of science, mathematics, social studies, the arts, literature and languages which leads to an understanding and appreciation of the values and the intellectual and artistic achievements of their culture and other cultures, and will take full advantage of opportunities to explore, develop and express their own uniqueness and creativity.

GOAL FOUR

Competence in Life Skills

Students are challenged to function successfully in multiple roles: as citizens, family members, parents, producers and consumers.

Therefore:

Connecticut public school students who complete secondary level studies will have the ability to make informed career choices; understand the responsibilities of family membership and parenthood; be prepared to undertake the responsibilities of citizenship in their communities, in the state, in the nation and in the world; and have the skills, knowledge and competence required for success in meaningful employment, or be qualified to enter postsecondary education.

GOAL FIVE

Understanding Society's Values

To be responsible citizens and contribute to positive change, students must understand and respect the underlying values of this society.

Therefore:

Connecticut public school students will appreciate diversity and understand the inherent strengths in a pluralistic society; they will understand and respond to the vital need for order under law; they will acquire the knowledge necessary to live in harmony with the environment, and actively practice conservation of natural resources, and they will respect the humanity they share with other people.

Appendix B
Legislation

The series of guides to curriculum development published in 1981 by the State of Connecticut Board of Education is consistent with the provisions of Sections 10-4 and 10-16b (or P.A. 79-128) of the Connecticut General Statutes.

Section 10-4. Duties of Board. (a) . . . shall prepare such courses of study and publish such curriculum guides . . . as it determines are necessary to assist school districts to carry out the duties prescribed by law . . . .

Section 10-16b. Prescribed courses of study. (a) In the public schools the program of instruction offered shall include at least the following subject matter, as taught by legally qualified teachers: the arts; career education; consumer education; health and safety; language arts, including reading, writing, grammar, speaking and spelling; mathematics; physical education; science; social studies, including, but not limited to, citizenship, economics, geography, government and history; and in addition, on at least the secondary level, one or more foreign languages, and vocational education.

(b) Each local and regional board of education shall on September 1, 1982, and annually thereafter at such time and in such manner as the commissioner of education shall request, attest to the state board of education that such local or regional board of education offers at least the program of instruction required pursuant to this section, and that such program of instruction is planned, ongoing and systematic.

(c) The state board of education shall make available curriculum materials and such other materials as may assist local and regional boards of education in developing instructional programs pursuant to this section.

Section 10-16c. State Board to develop family life education curriculum guides. The state board of education shall, on or before September 1, 1980, develop curriculum guides to aid local and regional boards of education in developing family life education programs within the public schools. The curriculum guides shall include, but not be limited to, information on developing a curriculum including family planning, human sexuality, parenting, nutrition and the emotional, physical, psychological, hygienic, economic and social aspects of family life, provided the curriculum guides shall not include information pertaining to abortion as an alternative to family planning.

Section 10-16d. Family life education programs not mandatory. Nothing in sections 10-16c to 10-16f, inclusive shall be construed to require any local or regional board of education to develop or institute such family life education programs.

Section 10-16e. Students not required to participate in family life education programs. No student shall be required by any local or regional board of education to participate in any such family life program which may be offered within such public schools. A written notification to the local or regional board by the student's parent or legal guardian shall be sufficient to exempt the student from such program in its entirety or from any portion thereof so specified by the parent or legal guardian.

Section 10-16f. Family life programs to supplement required curriculum. Any such family life program instituted by any local or regional board of education shall be in addition to and not a substitute for any health education, hygiene or similar curriculum requirements in effect on October 1, 1979.

Section 10-19. Effect of alcohol, nicotine or tobacco and drugs to be taught. Training of personnel. The effect of alcohol, of nicotine or tobacco and of drugs, as defined in subdivision (17) of section 19-443 on health, character, citizenship and personality development shall be taught every academic year to pupils in all grades in the public schools; and, in teaching such subjects, textbooks and such other materials as are necessary shall be used. Institutions of higher education approved by the state board of education to train teachers shall give instruction on the subject prescribed in this section and concerning the best methods of teaching the same. The state board of education and the board of higher education in consultation with the commissioner of mental health, the drug advisory council and the Connecticut state alcohol council shall develop health education programs for elementary and secondary schools and for the training of teachers, administrators and guidance personnel with reference to the effects of nicotine or tobacco, alcohol and drugs.

Section 10-220a. In-service training. Drug and alcohol education. (a) Each local or regional board of education shall provide an in-service training program for its teachers, administrators and guidance personnel who hold the provisional or standard certificate. Such program shall be approved by the state board of education, and shall provide such teachers, administrators and guidance personnel with information as to the nature and the relationship of drugs, as defined in subdivision (17) of section 19-443, and alcohol to health and personality development, and procedures for discouraging their abuse.

(b) Each local or regional board of education shall establish an ongoing program on the use and the relationships of such drugs and alcohol to health and personality development as a part of a health education program, to be included in the curriculum from kindergarten through grade twelve, which shall be coordinated with educational programs developed under subsection (a) of section 10-19. Such program shall be submitted to the state board of education for approval by said board in accordance with such regulations as it may adopt.

Section 10-220b. Policy statement on drugs. Each local and regional board of education shall adopt and file with the state board of education a written policy statement in conformity with section 10-154a, on (1) the use, sale or possession of controlled drugs as defined in subdivision (8) of section 19-443, on school property, (2) procedures for referring drug users, sellers or persons who have such drugs in their possession to such bodies or agencies as said board deems appropriate, and (3) procedures for cooperation with law enforcement officials.

Appendix C
Health Education Program Philosophy

Sample

Programs in drug abuse, venereal disease, smoking, pollution, etc., often are initiated as a response to a crisis situation. Too frequently the consequences of behavior become the focus of health education while the motivations behind these behaviors go unattended. Programs based on behavior which do not consider underlying needs and motives often fail to achieve the goal of prevention because they are not aimed at the real problem.

The problem of smoking and its hazards to health provides a good example. Programs designed to deal with smoking usually emphasize tobacco and its influence on the circulatory and respiratory systems. It seems illogical, knowing the facts about smoking, that any rational person would smoke. Yet people do, and repeated surveys indicate that tobacco use is on the increase. Obviously something is wrong! Apparently, people are concerned with and need to learn something very different from what is usually taught. The behavior of smoking is but a symptom of these needs. While a lecture on lung cancer and heart disease should be part of a program, a youngster also needs to learn how to handle peer group pressure and grow up without hurting himself/herself.

Every individual seems to have a basic need to grow and mature. Virtually everything a person does represents an attempt to fulfill these needs. Sometimes, because of insufficient or distorted experiences, individuals misinterpret their needs and behave in such a way as to foster growth and maturation in one dimension at the expense of other dimensions. The youngster who smokes, for example, may satisfy her/his immediate need for peer acceptance and adult self-image, but in the long run, there may be physical changes in his/her circulatory and respiratory system which are detrimental to her/his health. Equally as important, if not more so, he/she may learn to value the use of an external crutch in handling social and emotional stress rather than learning how to draw on her/his internal resources to meet his/her needs.

Helping individuals satisfy their needs to grow and mature as a total person is the challenge our health education program faces today. Our program attempts to develop curriculum based on the whole person, not just his body; upon individual needs rather than desires; upon respect rather than fear and upon analytical thinking rather than memory. With these goals in mind the health education program utilizes techniques designed to help people discover and develop their potential, rather than accepting the roles cast for them by others; to help them analyze problems rather than accept the analyses of others; and to explore alternatives instead of seeking packaged solutions.

In developing such health programs it seems logical to start with the concerns of youngsters as manifested by the questions they ask. These questions reveal concerns in three basic categories:

Concerns about self-characteristics, structure, function, potential, needs and the like. These are best summed up by the universal question: WHO AM I?

Concerns about influences—jobs, personality, drugs, sexuality, pollution and the like. These are summarized in the question: WHAT CAN INFLUENCE ME?

Concerns about making decisions—values, alternatives, control over environment, consequences of behavior and the like—best summed up by the question: HOW CAN I CONTROL INFLUENCES?

The task is not small nor can we expect to accomplish it overnight. However, if we continually focus on the needs of youngsters and are not tempted to respond only to crises situations, we will get at the heart of most of the contemporary health problems of youngsters.

Adapted from: Newington (CT) Public Schools

Appendix D
Student Questionnaire

Sample

The following questions are the kinds which can be used with students in grades 7–12. Students in the elementary grades can be more profitably surveyed informally through discussions with their teachers or committee members. Surveys of this nature should always be given anonymously.

> **Directions:** We are looking at health and safety education in our school district. Read each of the following questions and answer them in terms of your own experiences in school.

1. Below is a list of health topics. Put a check before **any** which you have had in the last year.

___ community health
___ environmental factors and health
___ being a good health consumer
___ how to prevent disease
___ common diseases
___ family life topics
___ first aid techniques
___ CPR
___ safety rules
___ use and abuse of alcohol
___ use and abuse of drugs
___ how the body grows and develops
___ signs of good and poor mental health
___ how to cope with mental health problems
___ how to get along with others
___ personal values and health
___ proper food habits and selection
___ personal health habits
___ maintaining physical fitness
___ accident prevention
___ use and abuse of cigarettes

2. In grades 7–12, have you had a course in health education? ____ Yes ____ No
   If so, in what year(s)? (please circle) 7 8 9 10 11 12

   What was the title of the course(s)? _____

3. From the list of topics you have had this year (question 1), list the three you think are most important.

   a. _____ b. _____

   c. _____

4. From the topics you have studied, list the one that you think should be dropped or changed.

   _____

5. List any topics which you feel ought to be covered in health education in our school district and are not now covered.

   a. _____ b. _____

   c. _____ d. _____

6. Check which of the following are used as resources in your health education classes.

   ____ teachers
   ____ nurse
   ____ doctor
   ____ community agency persons
   ____ clergy
   ____ movies/television
   ____ textbooks
   ____ newspapers/magazines
   ____ demonstrations
   ____ simulations
   ____ other (be specific) _____

7. What two resources do you find most effective in teaching you about health education?

   a. _____ b. _____

8. Make any other comments about health education in our district that you would like.

   _____

   _____

Adapted from a questionnaire developed in Fulton, Missouri

Appendix E
Questionnaires for Community Members

Sample

Input from parents and other community members is vital in the curriculum development process. The two questionnaires that follow contain examples of the kinds of questions that might be used to gather data. In most cases, these should be given anonymously.

Parent Questionnaire

Directions: We are looking at the health and safety curriculum in our school district. Please help us evaluate this program and establish future direction by completing this questionnaire and returning it by _____ (date) _____ to _____ (person) _____.

1. Grade levels of your children: (Please circle each one that applies.)

   K 1 2 3 4 5 6 7 8 9 10 11 12

2. Below is a list of topics in health and safety education. Please check all those which you feel should be in the curriculum.

   ____ community health
   ____ environmental factors and health
   ____ being a good health consumer
   ____ safety rules for the road
   ____ accident prevention
   ____ how the body grows and develops

___ how to prevent disease

___ common diseases

___ family life topics

___ first aid techniques

___ emergency procedures such as cardiopulmonary resuscitation

___ safety rules for the home

___ safety rules for the workplace

___ use and abuse of alcohol

___ signs of good and poor mental health

___ how to cope with mental health problems

___ how to get along with others

___ personal values and health

___ proper food habits and selection

___ personal health habits

___ maintaining physical fitness

___ use and abuse of cigarettes

___ use and abuse of drugs

3. Of the topics which you checked in question 2, select the three you think are most important at each of the following grade levels and list them:

Elementary

1. _____

2. _____

3. _____

Middle School/Junior High

1. _____

2. _____

3. _____

Senior High

1. _____

2. _____

3. _____

Adapted from a questionnaire developed in Fulton, Missouri

Continued on page 74

Appendix E (continued)

Health-Related Agencies Questionnaire

An explanatory letter stating the purposes of this survey and signed by the superintendent should be mailed with this questionnaire to the local agencies, seeking their input. In addition, a stamped return envelope will insure a greater percentage of return.

Agency: _____

Contact person: _____

Directions: We are examining the health and safety curriculum. Please help us by responding to these questions.

1. Below is a list of topics in health and safety education. Please check all those which you feel should be in the curriculum.

___ community health
___ environmental factors and health
___ being a good health consumer
___ how to prevent disease
___ common diseases
___ family life topics
___ first aid techniques
___ emergency procedures such as CPR
___ safety rules for the home
___ safety rules for the workplace
___ safety rules for the road
___ use and abuse of alcohol
___ accident prevention
___ use of community agencies
___ how the body grows and develops
___ signs of good and poor mental health
___ how to cope with mental health problems
___ how to get along with others
___ role of personal values in health
___ proper food habits and selection
___ personal health habits
___ maintaining physical fitness
___ use and abuse of cigarettes
___ use and abuse of drugs

2. What other topics, if any, do you feel should be included in health education in this community?

_____ _____

_____ _____

3. Knowing this community as you do, which three topics do you feel require the most stress in health education?

1. _____ 2. _____

3. _____

4. What recommendations for health or health-related teaching aids would you make?

a. _____ b. _____

c. _____ d. _____

5. If your agency has teaching aids available for use in our schools, what are they? If there are many different titles, please list the general kinds of materials available.

a. _____ b. _____

c. _____ d. _____

6. Can you or someone else in your agency serve as a volunteer consultant in a health subject for the schools? If so, what topic or topics can you cover?

Person _____ Phone No. _____

Topics 1. _____

2. _____

7. We are forming a health advisory committee for the school district. Would you be willing to serve on such a committee?

___ Yes ___ No If yes, do you mean this year? ___ Yes ___ No

At some time in the future? ___ Yes ___ No

Adapted from a questionnaire developed in Fulton, Missouri

Appendix F
Teacher Questionnaire

Sample

A questionnaire like this may be used to inventory the current status of health education in each of the major conceptual areas. The committee should be careful to include questions which will yield enough data to be useful but will not burden teachers with too much paper work to be completed. The same questionnaire can be used with administrators to compare their perceptions of the current program.

Name _____

Subject/grades/levels taught: **Number of students:**

_____ _____

_____ _____

_____ _____

Directions: The following is a survey of what is presently being taught in health and safety education in our district. Please read each question carefully, consider what you personally teach in these areas as part of your planned program, and answer the questions accordingly.

1. Do you presently teach health education:
   a. integrated into your regular course work? ___ Yes ___ No
   b. as separate units within other courses? ___ Yes ___ No
   c. as separate courses? ___ Yes ___ No If yes, what titles?

   _____ _____

2. If you were to evaluate the total health education program at your grade level(s), would you say it is
   ___ very ineffective ___ ineffective ___ fair ___ effective ___ very effective

3. Do you feel that your preparation to teach health and safety education is
   ___ inadequate ___ fair ___ adequate ___ comprehensive ___ certified in area

4. Below is a list of topics in health and safety education. Please check **all** those which you presently teach in a planned way at your grade or grade levels.

___ community health

___ environmental factors and health

___ being a good health consumer

___ how to prevent disease

___ common diseases

___ family life topics

___ first aid techniques

___ emergency procedures such as CPR

___ safety rules for the home

___ safety rules for the workplace

___ safety rules for the road

___ accident prevention

___ use of community agencies

___ how the body grows and develops

___ signs of good and poor mental health

___ how to cope with mental health problems

___ how to get along with others

___ role of personal values in health

___ proper food habits and selection

___ personal health habits

___ maintaining physical fitness

___ use and abuse of cigarettes

___ use and abuse of alcohol

___ use and abuse of drugs

5. Please list any additional topics which you cover.

a. _____ b. _____

c. _____ d. _____

6. List any topics which you feel should be dropped.

a. _____ b. _____

c. _____ d. _____

7. List any topics which you feel should be added to your grade level.

a. _____ b. _____

c. _____ d. _____

8. Check which of the following resource people are used in your classroom.

___ health teacher

___ doctor

___ community agency representatives

___ nurse

___ other school personnel

___ clergy

Appendix F (continued)

9. Check which of the following kinds of resources are part of your health education program.

___ audiovisuals ___ pamphlets ___ simulations

___ instructional television ___ periodicals ___ textbooks

___ others (specify) _____

10. Check which of the following strategies are used in your classes.

___ activities ___ inquiry ___ peer teaching

___ community involvement ___ lecture ___ projects

___ group discussion ___ media ___ role playing

___ others (specify) _____

11. List the materials you use most often in your classes.

_____

_____

_____

12. List the two most critical needs for health education at your grade level.

1. _____ 2. _____

13. List the greatest strengths of health education at your grade level.

1. _____ 2. _____

14. Would you be willing to serve on a health and safety education curriculum committee?

___ Yes ___ No

15. What staff development activities would be most useful to you?

_____

Adapted from a questionnaire developed in Fulton, Missouri

Appendix G
Resources

There are abundant resources available for the school health and safety educational program. Sources of free or low-cost resource materials have been included in this appendix for use by curriculum committees. From these sources, packets of appropriate materials may be developed for the curriculum objectives of the local district.

Usually, a form letter sent to the various agencies requesting a catalog of their educational materials suitable for classroom use will bring a prompt reply. Although many health agencies have national headquarters, most prefer that you seek assistance from their local branches within the state or from the state offices.

Local agencies such as health departments, community health agencies, hospitals, police departments, associations of health professionals and youth service agencies often maintain a speakers bureau or provide resource persons. Direct contacts with these agencies should elicit what resources are available. Local school systems should make a strong effort to work with the agencies within the community.

Connecticut Resources
including local addresses of national organizations

Alcoholic Anonymous, Public Information Chairman, 75 Benton Street, Manchester, CT 06040 Telephone: 649-1831

American Cancer Society, State Office, 15 Village Lane, P.O. Box 410, Wallingford, CT 06492

Bridgeport	Greater Bridgeport Branch, 499 Clinton Avenue, Bridgeport, CT 06605
Danbury	Danbury Branch, 57 James Street, Danbury, CT 06810
Darien	Southern Fairfield County Branch, 23 Leroy Avenue, Darien, CT 06820
Greenwich	Greenwich Health Association Branch, 45 East Putnam Avenue, Greenwich, CT 06830

Appendix G (continued)

Hartford	Greater Hartford Branch, 670 Prospect Avenue, Hartford, CT 06105
Manchester	Manchester Branch, 237 East Center Street, Manchester, CT 06040
Middletown	Middlesex/Meriden/Wallingford Branch, Route 66, Meriden Road, Middletown, CT 06457
New Britain	New Britain Unit, 70 Grove Hill, New Britain, CT 06052
New Haven	South Central Branch, Drawer H, Amity Station, New Haven, CT 06525
New London	New London Branch, 120 Broad Street, New London, CT 06320
North Windham	Windham Branch, Post Office Box 117, North Windham, CT 06256
Norwich	Norwich/Quinebaug Branch, 257 Main Street, Room 301, Norwich,CT 06360
Torrington	Litchfield North Branch, 179 Water Street, Torrington, CT 06790
Waterbury	Greater Waterbury Branch, 175 Grove Street, Waterbury, CT 06710

American Diabetes Association, Connecticut Affiliate, 17 Oakwood Avenue, West Hartford, CT 06119

American Heart Association, Connecticut Affiliate, 71 Parker Avenue, Meriden, CT 06450

Hartford	Greater Hartford Branch, 310 Collins Street, Hartford, CT 06105
New Haven	South Central Connecticut Chapter, Post Office Box 1673, 1184 Chapel Street, New Haven, CT 06507
Norwalk	Fairfield County Chapter, 15 Bettswood Road, Norwalk, CT 06851
Norwich	Eastern Connecticut Division, 90 Town Street, Norwich, CT 06360
Waterbury	Northwestern Connecticut Division, 405 Highland Avenue, Waterbury, CT 06708

American National Red Cross, Connecticut Division Headquarters, 209 Farmington Avenue, Farmington, CT 06032

Area Health Education Center, Inc., 749 Albany Avenue, Hartford, CT 06112

Aspetuck Valley Health District, 180 Bayberry Lane, Westport, CT 06880

Blue Cross/Blue Shield of Connecticut, Public Relations and Advertising Department, 370 Bassett Road, North Haven, CT 06473

Cancer Information Service, Yale University, Comprehensive Cancer Center, New Haven, CT 06520 Telephone: 1-800-922-0824

Chesprocott Health District, 275 Maple Avenue, Cheshire, CT 06410

Community Health Services, 520 Albany Avenue, Hartford, CT 06120 Telephone: 249-9625

Connecticut Advisory School Health Council, Dr. Estelle Siker, Department of Health Services, 79 Elm Street, Hartford, CT 06106

Connecticut Alcohol and Drug Abuse Commission, 999 Asylum Avenue, Hartford, CT 06115

Connecticut Association for Health, Physical Education, Recreation and Dance, Robert Laemel, President, 35 Davis Street, New Haven, CT 06517

Connecticut Health Systems Agencies

Area		Telephone
I	Southwestern Connecticut Health Systems Agency, Inc., 20 North Main Street, South Norwalk, CT 06854	853-1501
II	South Central Connecticut Health Systems Agency, 131 Bradley Road, Woodbridge, CT 06525	397-5400
III	Eastern Connecticut Health Systems Agency, 12 Case Street, Suite 311, Norwich, CT 06360	886-1996
IV	Health Systems Agency of North Central Connecticut 999 Asylum Avenue, Hartford, CT 06105	249-7581
V	Northwestern Connecticut Health Systems Agency, 20 East Main Street, Waterbury, CT 06702	757-9601

Connecticut Hospital Association, P.O. Box 90, Wallingford, CT 06492

Connecticut Lung Association, State Office, 45 Ash Street, East Hartford, CT 06108

East Hartford	Hartford County Branch, 45 Ash Street, East Hartford, CT 06108
New Haven	South Central Branch, 364 Whitney Avenue, New Haven, CT 06511
Norwalk	Fairfield County Branch, 12 Byington Place, Norwalk, CT 06850
Waterbury	North Western Branch, 211 Schraft Drive, Waterbury CT 06705

Connecticut Public Television, 24 Summit Street, Hartford, CT 06106

Connecticut Society to Prevent Blindness, P.O. Box 2020, Madison, CT 06443

Connecticut State Dental Society, 60 Washington Street, Hartford, CT 06106

Connecticut State Department on Aging, Public Information Offices, 80 Washington Street, Hartford, CT 06106 Telephone: 566-7770

Connecticut State Department of Education, P.O. Box 2219, Hartford, CT 06115

Connecticut State Department of Health Services, 79 Elm Street, Hartford, CT 06115 Telephone: 566-4800

Information and referral on Connecticut High Blood Pressure, Nutrition Awareness, Public Health Education and Smoking Cessation.

Mansfield	Northeastern, Route 44A, Mansfield Depot, CT 06252	729-9395
Norwich	Southeastern, 401 West Thames Street, Norwich, CT 06360	889-8341
Shelton	South Central, Lauren Heights Hospital, Shelton, CT 06484	735-9513
Wilton	Southwestern, 32 Old Ridgefield Road, P.O. Box 306, Wilton, CT 06897	762-8301

Appendix G (continued)

Connecticut State Department of Mental Health, Attention: Chief of Division of Community Services, 90 Washington Street, Hartford, CT 06106 Telephone: 566-2737

Region		
1	Security Building, 1115 Main Street, Suite 615, Bridgeport, CT 06604	579-6723
2	One State Street, New Haven, CT 06511	789-7968
3	Norwich Hospital, P.O. Box 508, Norwich, CT 06360	889-7361 Ext. 739
4	233 Main Street, Room 700, New Britain, CT 06050	827-7790
5	Medical Arts Building, 95 North Main Street, Suite 206, Waterbury, CT 06702	754-4151

Connecticut State Medical Society, 160 St. Ronan Street, New Haven, CT 06511

Danbury Health Department, 254 Main Street, Danbury, CT 06810

East Hartford Health Department, 740 Main Street, East Hartford, CT 06108

Fairfield Health Department, Town Hall, Fairfield, CT 06430

Fairhaven Community Health Clinic, Inc., 374 Grand Avenue, New Haven, CT 06513 Telephone: 777-7411

Governor's Committee on Fitness, c/o Joni E. Barnett, Yale University, Payne Whitney Gymnasium, 70 Tower Parkway, New Haven, CT 06525

Greenwich Health Department, Town Hall Annex, Greenwich, CT 06830

Hartford Health Department, 80 Coventry Street, Hartford, CT 06112

Hartford Hospital Speakers Bureau, Public Information, Cheney Building, Hartford, CT 06115

Hill Health Center, 400 Columbus Avenue, New Haven, CT 06519

Insurance companies

Aetna Life and Casualty, 151 Farmington Avenue, Hartford, CT 06105

Connecticut General Life Insurance Company, 900 Cottage Grove Road, Bloomfield, CT 06002

Connecticut Mutual Life Insurance Company, 140 Garden Street, Hartford, CT 06105

Hartford Insurance Group, Hartford Plaza, 690 Asylum Avenue, Hartford, CT 06115

Metropolitan Life Insurance Company, 80 South Main Street, West Hartford, CT 06107

Phoenix Mutual Life Insurance Company, 3 Constitution Plaza, Hartford, CT 06103

The Prudential Insurance Company of America, 65 La Salle Road, West Hartford, CT 06107

The Travelers Insurance Companies, 1 Tower Square, Hartford, CT 06115

Lifestyle Council of Connecticut, P.O. Box 2080, Hartford, CT 06145 Telephone: 1-800-842-2220

Lower Naugatuck Valley Health Department, 75 Liberty Street, Ansonia, CT 06401

Manchester Health Department, Alice Turek, M.D., Director, 41 Center Street, Manchester, CT 06040

March of Dimes

New Haven	New Haven Chapter, 135 College Street, Room 205, New Haven, CT 06510	787-7459
Norwich	Eastern Connecticut Chapter, 35 Lafayette Street, Norwich, CT 06360	889-3883
West Hartford	Northern Connecticut Chapter, 10 North Main Street, Room 321, West Hartford, CT 06017	521-7900
Wilton	Fairfield County Chapter, 57 Danbury Road, Wilton, CT 06897	834-0386
Winsted	Litchfield County Chapter, 434 Main Street, P.O. Box 11, Winsted, CT 06098	379-0505

Mental Health Association of Connecticut, Inc., 56 Arbor Street, Hartford, CT 06106 Telephone: 1-800-842-1501

New Britain Health Department, 27 West Main Street, New Britain, CT 06051

New England Dairy and Food Council, Area Office, Connecticut, 28 Grand Street, Hartford, CT 06106

Northeast District Health Department, 35 School Street, Box 690, Danielson, CT 06239

Plainville YMCA, Farmington Avenue, Plainville, CT 06062

Quinnipiak Valley Health Department, 1819 Dixwell Avenue, Hamden, CT 06518

Regional Educational Service Centers, see Appendix I.

Self-Care Program, Yale University, Department of Epidemiology and Public Health, 60 College Street, New Haven, CT 06510

Seventh-Day Adventist Church, "Health Beat" Program, 870 Prospect Avenue, Hartford CT 06105

Stamford Health Department, 229 North Street, Stamford, CT 06902

Tel-Med

Hartford	St. Francis Hospital and Medical Center Foundation, Inc., 114 Woodland Street, Hartford, CT 06105	548-4166
New Haven	Hospital of St. Raphael Foundation, 1450 Chapel Street, New Haven, CT 06511	789-3000
Willimantic	Windham Community Memorial Hospital, Mansfield Avenue, Willimantic, CT 06226	423-9201

Waterbury Health Department, 236 Grand Street, Waterbury, CT 06702

West Hartford Health Department, 28 South Main Street, West Hartford, CT 06107

Federal Health Education Agencies

Center for Health Promotion and Education, 1600 Clifton Road, NE, Atlanta, GA 30333

Office of Comprehensive School Health, Bureau of School Improvement, 3700 Donahoe Building, 400 Maryland Avenue, SW, Washington, DC 20202

Office of Health Information, Health Promotion, Physical Fitness and Sports Medicine, Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201

Appendix G (continued)

Film Sources

Center for Instructional Media and Technology, The University of Connecticut, Storrs, CT 06268

Connecticut State Department of Children and Youth Services, 170 Sigourney Street, Hartford, CT 06105

Connecticut State Department of Health Services, Bureau of Public Health Information, 79 Elm Street, Hartford, CT 06106

National Organizations

Agency for Instructional Television, Box A, Bloomington, IN 47401

American Academy of Pediatrics, 1801 Hinman Avenue, Box 1034, Evanston, IL 60201

American College Health Association, 152 Rollins Avenue, Suite 208, Rockville, MD 20852

American Dental Association, Bureau of Health Education and Audiovisual Services, 211 East Chicago Avenue, Chicago, IL 60611

American Health Foundation, "Know Your Body" Program, 320 East 43rd Street, New York, NY 10019

American Medical Association, Department of Health Education, 535 North Dearborn Street, Chicago, IL 60610

American Nurses Association, 2420 Pershing Road, Kansas City, MO 64108

American Public Health Association, 1015 Fifteenth Street NW, Washington, DC 20005 Telephone: (202) 789-5600

American School Health Association, Kent, OH 44240

Association for the Advancement of Health Education, 1900 Association Drive, Reston, VA 22091

National Center for Health Education, 211 Sutter Street, San Francisco, CA 94108

National Congress of Parents and Teachers, 700 North Rush Street, Chicago, IL 60611

Nutrition Today Society, 703 Giddings Avenue, P.O. Box 1829, Annapolis, MD 21404

Publications

Books

Anderson, C.L. *School Health Practice*, 5th edition. St. Louis: C.V. Mosby Co., 1972.

Bedworth, David and A. Bedworth. *Health Education, A Process for Human Effectiveness*. New York: Harper & Row Pubs., Inc., 1978.

Brooks, Natalie A. and M. Stewart, revisers. *Turner's Personal and Community Health*, 15th edition. St. Louis: C. V. Mosby Co., 1979.

Combs, Barbara J., Dianne R. Hales and Brian K. Williams. *An Invitation to Health: Your Personal Responsibility*. Reading, MA: Benjamin/Cummings Publishing Co., 1980.

Dalis, Gus T. and B. Strasser. *Teaching Strategies for Values Awareness and Decision Making in Health Education*. Springfield, IL: Charles B. Slack, Inc., 1977.

Dintimans, George B. and Jerrold S. Greenberg. *Health Through Discovery*. Reading, MA: Addison-Wesley Publishing Co., Inc., 1979.

Engs/Barnes/Wantz. *Health Games Students Play*. Dubuque, IA: Kandall/Hunt Publishing Co., 1975.

Ensor, P.G. and R.K. Means. *Instructor's Resource and Methods Handbook for Health Education*, 2nd edition. Boston: Allyn and Bacon, Inc., 1977.

Fassbender, William. *You and Your Health*, 2nd edition. New York: John Wiley & Sons, Inc., 1980.

Green, L.W. *Health Education Planning—A Diagnostic Approach*. Palo Alto, CA: Mayfield Publishing Co., 1980.

Haag, Jessie Helen. *School Health Program*, 3rd edition. Philadelphia: Lea & Febiger, 1972.

Joint Committee on Health Problems in Education of the NEA and AMA. *Health Education*, 5th edition. Washington, DC: National Education Association, 1961.

Kime, Robert E., Richard G. Schlaadt and Leonard E. Tritsch. *Health Education: An Action Approach*. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1977.

Kogan, Benjamin A. *Health*, brief edition. New York: Harcourt Brace Jovanovich, Inc., 1976.

Lazes, Peter. *The Handbook of Health Education*. Germantown, MD: Aspen Systems Corp., 1979.

Oberteuffer, D., O. Harrelson and M. Pollock. *School Health Education*, 5th edition. New York: Harper & Row Pubs., Inc., 1972.

Read, D., S. Simon and J. Goodman. *Health Education: The Search for Values*. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1977.

Read, Donald and Walter Green. *Creative Teaching in Health*. New York: Macmillan Publishing Corp., 1980.

Sinacore, John S. and Angela C. Sinacore. *Introductory Health: A Vital Issue*. New York: Macmillan Publishing Corp., 1975.

Sorochon, Walter D. *Promoting Your Health*. New York: John Wiley & Sons, Inc., 1981.

U.S. Consumer Product Safety Commission. *You Make the Difference: A Health and Safety Educational Resources Guide*. Vols. 7–9 and 10–12. Washington, DC: 1980.

Wilgoose, C. E. *Health Education in the Elementary School*, 3rd edition. Philadelphia: W.B. Saunders Co., 1969.

Wilgoose, C.E. *Health Teaching in Secondary Schools*. Philadelphia: W.B. Saunders Co. 1972.

Periodicals

American Journal of Nursing, 2420 Pershing Road, Kansas City, MO 64108

American Journal of Public Health, 1015 Fifteenth Street, NW, Washington, DC 20005

Current Awareness in Health Education, Center for Disease Control, Bureau of Health Education, Building 4, Atlanta, GA 30333

Contains citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents, as well as descriptions of programs in health education. Published monthly.

Focal Points, Center for Health Promotion and Education, Center for Disease Control, 1600 Clifton Road, Atlanta, GA 30333

Appendix G (continued)

Health Education, American Alliance for Health, Physical Education, Recreation and Dance, 1900 Association Drive, Reston, VA 22091

Published bi-monthly.

Journal of School Health, American School Health Association, Kent, OH 44240

Official journal of the American School Health Association. Published ten times per year.

Nutrition Today, 703 Giddings Avenue, P. O. Box 1829, Annapolis, MD 21404

Public Health Reports (Monthly), Department of Health and Human Services, Health Resources Administration, 3700 East West Highway, Hyattsville, MD 20782

Appendix H
Evaluation Guide

Sample

Item to be Evaluated	Yes	To a Degree	No	Change Needed
A. Organization of Health Curriculum				
1. Is there a written statement which defines philosophy, major concepts, and objectives, and is available and familiar to all teachers?	___	_____	___	_____
2. Is an advisory committee used to assure input in curriculum planning from students, teachers, parents, and related community personnel?	___	_____	___	_____
3. Does a specific staff member have the responsibility for planning, coordinating, and integrating the program into health services and related areas of instruction?	___	_____	___	_____
4. Are requirements (credit, class size, facilities, additional elective courses) comparable to other academic subjects?	___	_____	___	_____
5. Is the community used as a resource for a variety of learning experiences?	___	_____	___	_____
6. Are the health education needs of high-risk and special education students met?	___	_____	___	_____
7. Is an annual review conducted to determine relevancy and the extent to which established objectives are being met?	___	_____	___	_____

Appendix H (continued)

Item to be Evaluated	Yes	To a Degree	No	Change Needed
B. Content and Materials				
1. Is an affective/cognitive approach used which provides learning opportunities to promote positive attitudes and health behavior, decision-making skills, critical thinking, and personal responsibility for health?	___	_____	___	_____
2. Have the following elements been considered in the development of the curriculum:				
a. scope (inclusion of appropriate topics at various levels)?	___	_____	___	_____
b. sequence (succeedingly higher levels of complexity, greater depth and breadth)?	___	_____	___	_____
c. continuity (vertical organization)?	___	_____	___	_____
d. flexibility?	___	_____	___	_____
e. adaptability?	___	_____	___	_____
3. Are the objectives or goals				
a. suited to the grade level?	___	_____	___	_____
b. measurable?	___	_____	___	_____
c. achievable in the given time allotment?	___	_____	___	_____
d. achievable through activities within the realm of the course?	___	_____	___	_____
e. the result of an educational need of the student?	___	_____	___	_____
4. Is there integration among health education topics and between health education and other subjects (science, physical education, home economics, social studies)?	___	_____	___	_____
5. Does the curriculum provide for consideration of the following areas:				
a. values and decision making?	___	_____	___	_____
b. growth and development?	___	_____	___	_____
c. food selection and nutrition?	___	_____	___	_____
d. lifetime exercise and activity?	___	_____	___	_____
e. rest and recreation?	___	_____	___	_____
f. dental health?	___	_____	___	_____
g. safety and first aid?	___	_____	___	_____
h. alcohol, tobacco, drugs?	___	_____	___	_____
i. dental health, personal adjustment, social relationships?	___	_____	___	_____

Item to be Evaluated	Yes	To a Degree	No	Change Needed
j. disease prevention and control?	___	_____	___	_____
k. health in the home, family life and relationships?	___	_____	___	_____
l. health protection in the community, consumer health?	___	_____	___	_____
m. family life and sex education?	___	_____	___	_____
n. personal health practices?	___	_____	___	_____
o. other health topics identified by teachers, students, advisory committee, etc.?	___	_____	___	_____
6. Are adequate funds available for current and scientifically accurate instructional materials?	___	_____	___	_____
7. Does the school library have materials and information to supplement the health instruction program?	___	_____	___	_____

C. **Student Motivation**

1. Are the needs, concerns and interests of the students incorporated into the health curriculum?	___	_____	___	_____
2. Are students involved in the curriculum design process?	___	_____	___	_____
3. Are visual aids, exhibits, charts and other teaching aids used to vary the teaching methods used in the classroom?	___	_____	___	_____
4. Are classroom lessons followed by practical experience or related to experiences of the students?	___	_____	___	_____
5. Is provision made for individual differences by giving a choice of required work, encouraging student suggestions and giving optional work for enrichment?	___	_____	___	_____
6. Are teacher expectations of student performance made clear at the beginning of the course and periodically throughout the course?	___	_____	___	_____

Appendix H (continued)

Item to be Evaluated	Yes	To a Degree	No	Change Needed
D. Teacher Preparation and In-Service Education				
1. Does teacher preparation meet state standards?	___	_____	___	_____
2. Are teachers with a degree in health education recruited for middle and secondary level classes?	___	_____	___	_____
3. Is an on-going program provided for teacher-planned in-service and professional growth opportunities?	___	_____	___	_____
4. Do in-service programs include				
a. use of curriculum consultants?	___	_____	___	_____
b. use of special health consultants?	___	_____	___	_____
c. faculty discussion of health council plans, recommendations and evaluation?	___	_____	___	_____
d. school visitation to study other programs?	___	_____	___	_____
e. use of professional health education publications?	___	_____	___	_____
f. teacher attendance at health education conferences and workshops?	___	_____	___	_____
E. Integration with School Health Services				
1. Does the health instruction program contribute to and make use of the health services programs?	___	_____	___	_____
2. Are special provisions made for handicapped students?	___	_____	___	_____
3. Are health screening programs provided to meet the needs of students and staff?	___	_____	___	_____
4. Is there a program to assure early identification of health problems with a plan for remedial action?	___	_____	___	_____
5. Is a health room with adequate supplies and equipment available at all times?	___	_____	___	_____
6. Are there established policies for				
a. communicable disease control?	___	_____	___	_____

Item to be Evaluated	Yes	To a Degree	No	Change Needed
b. a reporting system?	___	_____	___	_____
c. teacher-observation responsibilities?	___	_____	___	_____
d. teacher-nurse conferences? Immunizations, physical examinations?	___	_____	___	_____
7. Is health counseling provided as an integral component of the health education program?	___	_____	___	_____
8. Is the school nurse involved in team planning and review of individual students?	___	_____	___	_____
9. Is there a well-defined medical emergency plan which includes a minimum of three staff members trained to meet first aid and CPR emergencies?	___	_____	___	_____
F. Integration with Healthful School Environment				
1. Is the emotional climate in the school conducive to learning and to personal growth for every child?	___	_____	___	_____
2. Does the physical plant meet local and state requirements regarding				
a. structure?	___	_____	___	_____
b. heating?	___	_____	___	_____
c. lighting?	___	_____	___	_____
d. ventilation?	___	_____	___	_____
e. water?	___	_____	___	_____
f. waste system?	___	_____	___	_____
g. day-to-day maintenance?	___	_____	___	_____
3. Are there well-defined safety policies with periodic review in all areas including				
a. vocational department?	___	_____	___	_____
b. science laboratories?	___	_____	___	_____
c. athletic and playground programs?	___	_____	___	_____
d. lunchrooms?	___	_____	___	_____
e. bus and traffic safety?	___	_____	___	_____
f. fire and weather emergencies?	___	_____	___	_____

Appendix H (continued)

Item to be Evaluated	Yes	To a Degree	No	Change Needed
4. Is a proper balance maintained between curricular and noncurricular demands of students?	___	_____	___	_____
5. Does the school have an activity program designed to help meet the leisure, recreational and social needs of the students?	___	_____	___	_____
G. Evaluation of Students				
1. In systematically appraising the health performance of each student, are each of the following given consideration:				
a. the goals and objectives identified at the beginning of the course?	___	_____	___	_____
b. the student's knowledge of the subject matter?	___	_____	___	_____
c. the student's behavior and attitudes regarding personal health practices?	___	_____	___	_____

Source: American Medical Association. *Physician's Guide to the School Health Curriculum Process.* (Pamphlet) 1980

Appendix I
Regional Educational Service Centers

Area Cooperative Education Services (ACES)
800 Dixwell Avenue
New Haven, CT 06511

Capitol Region Education Council (CREC)
212 King Philip Drive
West Hartford, CT 06117

Cooperative Educational Services (CES)
11 Allen Road
Norwalk, CT 06852

Eastern Connecticut Regional Educational Service Center (EASTCONN)
R. R. 2
Willimantic, CT 06226

Long-Range Educational Assistance for Regional Needs (LEARN)
P. O. Box 220
East Lyme, CT 06333

Regional Educational Services Concept through United Effort (RESCUE)
R. R. 2, Goshen Road
Litchfield, CT 06759

Footnotes

1. Halbert Dunn, *High Level Wellness*, 7th edition (Arlington, VA: R. W. Beatty Ltd., 1972) Positive Health Bookshelf, vol. 1.
2. Donald B. Ardell, *High Level Wellness—An Alternative to Doctors, Drugs and Disease* (Emmaus, PA: Rodale Press, 1977).
3. School Health Education Study, *Health Education: A Conceptual Approach to Curriculum Design* (St. Paul, MN: 3M Press, 1967), p. 10.
4. D. Oberteuffer, O. Harrelson and M. Pollock, *School Health Education* (New York: Harper & Row Pubs., Inc., 1972), p. 10.
5. Adapted from Ibid., p. 11.
6. "Report of the 1972–73 Joint Committee on Health Education Terminology" Health Education Monographs (No. 33, 1973), pp. 65-66.
7. American Academy of Family Physicians, American Academy of Pediatrics, American Association of School Administrators, American College Health Association, American Dental Association, American Medical Association, American Nurses' Association, American School Health Association, Association for the Advancement of Health Education, Association of State and Territorial Health Officials, Association of State and Territorial Maternal and Child Health and Crippled Children Directors, National Association of School Nurses Inc. (affiliate of National Education Association), National Association of State Boards of Education, National Congress of Parents and Teachers, National School Boards Association, School Health Section of the American Public Health Association, Society of State Directors of Health, Physical Education and Recreation.
8. Committee on School Health, "Health Education," *Pediatrics*, 62, no. 1 (July 1978): 117.
9. U.S. Department of Health, Education and Welfare, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (Washington, DC: U.S. Government Printing Office, 1979).
10. *Connecticut's School Health Policy—A Report from the School Health Task Force to the Connecticut General Assembly* (January 1, 1980), p. 9.
11. Connecticut State Board of Education, "Response to the Report for the School Health Task Force to the Connecticut General Assembly" (February 1980).
12. David A. Bedworth and Albert E. Bedworth, *Health Education: A Process for Human Effectiveness* (New York: Harper & Row Pubs., Inc., 1978), p. 6.

13. Marian V. Hamburg, "When and Where Health Education," *It Can Be Done* (St. Paul, MN: 3M Education Press, 1968), pp. 23-24.
14. Education Commission of the States, *Recommendations for School Health Education—A Handbook for State Policymakers* (Denver, CO: 1981), p. 10.
15. Health Education Center, Health and Welfare Planning Association, *Guidelines for Planning and Implementing School Health Education Programs* (Pittsburgh: 1979), p. 2.
16. *Connecticut's School Health Policy—A Report from the School Health Task Force to the Connecticut General Assembly* (1980), pp. 12-13.
17. "Why Health Education in Your School" (Chicago: American Medical Association, 1974).
18. See K. Hetges and M. Hosokawa, "Delphi: Group Participation in Needs Assessment and Curriculum Development," *Journal of School Health* (October 1980), pp. 447–450, for information on how to use this technique.
19. Committee on School Health, "Health Education," *Pediatrics*, 62, no. 1 (July 1978): 117.
20. U.S. Department of Health, Education and Welfare, *The Primary Grades Health Curriculum Project*. Department of Health, Education and Welfare publication number (CDC) 80-8382 (Atlanta, GA: Center for Disease Control, 1980).
21. U.S. Department of Health, Education and Welfare, *The School Health Curriculum Project*. Department of Health, Education and Welfare publication number (CDC) 78-8359 (Atlanta, GA: Center for Disease Control, 1977).
22. Readers are referred to the separate publication, *A Guide to Curriculum Development in Family Life Education*, which has been available from the Connecticut State Board of Education since 1981. It addresses this topic in detail.
23. School Health Education Study, "Scope and Sequence Chart for a Unified and Comprehensive Program for Health Education, K–12" (St. Paul, MN: 3M Education Press, 1967).
24. School Health Education Project, "The Health Education Curricular Progression Chart" (San Bruno, CA: National Center for Health Education, 1978).
25. "Rationale for Family Life Education," in *A Guide to Curriculum Development in Family Life Education*, Connecticut State Board of Education, 1981, pp. 5–6, contains more complete curriculum information.

Connecticut State Department of Education

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Errol J. Terrell, Chief

Claire B. Reinhardt, Consultant, Health Occupations

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